(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

00159

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 99 Penna. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war ——— ✓

3. (a) FULL NAME Naomi Abell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Eugene E. Abell
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug 5 - 1915

8. AGE:	Years	Months	Days	If less than one day
about	29	4	28	... hrs. ... min.

9. Birthplace Snydersburg Md.
(Town, county, and state)
10. Usual occupation worked in Clothing Mfg.
11. Industry or business

FATHER
12. Name Earl Davidson
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden name Grace Sitzer
15. Birthplace Carroll Co. Md

16. Informant John J. Myers Jr.
Address Westminster Md

17. Burial Date thereof Jan 4 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Carrollton, Carroll Co. Md.

18. Funeral director Frank A. Newell
Address Pikesville. Md.

19. 1 - 2 - 1945 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany. 1st. 1945, at 4-30 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from ... 19..., to ... 19...~~
~~and that I last saw h... alive on ... 19...~~

Immediate cause of death	DURATION
Passenger Auto Accident	
Due to Highway	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ Accident Date of 1-1-45
Where did injury occur? Owings Mills Balto Md
(City or town) (County) (State)
Injured at ~~home, farm, industry,~~ public place (where?) Highway
Means of injury Auto Accident Injured at work? no

23. SIGNATURE W. T. O'Mara Depy M. E.
M. D. or other
Address Pikesville Md Date signed Jany 1st 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00151

CERTIFICATE OF DEATH

Reg. Dist. No. 35

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Hereford (Monkton P.O.)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 6 years

Hospital, Institution, or street address where death occured:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: Hereford (Monkton, P.O.)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Ahrens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7 - ?

8. AGE: Years 77 | Months | Days | If less than one day hrs. min.

9. Birthplace Whitehall Balto. Co., Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name —

13. Birthplace —

MOTHER 14. Maiden name —

15. Birthplace —

16. Informant Mrs. R. Neukirgen

Address Monkton, Md. 1945

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3 1945 (month) (day) (year)

Cemetery or crematory Jessops

Location Sparks, Md

18. Funeral director Landon M. Bowles

Address Sparks, Md.

19. Jan 1 1945 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 5-A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death Chronic myocarditis — DURATION

Due to

Due to

Other conditions Generalized arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other

Address Parkton, Md Date signed 1/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

P 66152

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 79 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1832 N. Collington Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: WILLIAM F. ALT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married---Sep.

6.(b) Name of husband or wife: Barbara E. Alt

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 1-24-92

8. AGE: Years	Months	Days	If less than one day
52	11	20	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Casper Alt
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Silber
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-45 (month) (day) (year)

Cemetery or crematory: Baltimore Cem.

Location: North Ave.

18. Funeral director: John C. Miller Inc.

Address: 2435 E. Pliny St.

19. 1/17 (Date rec'd by registrar) 1945 A. W. Kelland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1945 at 3:55 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 27, 1944 to January 14, 1945 and that I last saw him alive on January 14, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pulmonary far advanced active III	2 Yrs.
Due to	
Due to	
Other conditions: Adhesions abdominal	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: Injured at work? No

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIR. M.D. or other

Address: Fort Howard, Maryland Date signed 1-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec d. U.S.
1/17/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00153

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Whiteford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emory Elsworth Barrett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12/23/1877

8. AGE: Years	Months	Days	If less than one day
67		27	..... hrs. ..... min.

9. Birthplace: Whiteford, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Road construction

FATHER 12. Name: Nelson Barrett

FATHER 13. Birthplace: Whiteford, Maryland

MOTHER 14. Maiden name: Ella Harman

MOTHER 15. Birthplace: New Park, Penna.

16. Informant: Hospital Records

Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof Jan 22 1945 (month) (day) (year)

Cemetery or crematory: State Ridge Cem.

Location: Delta, Pa.

18. Funeral director: Hubert P Hankins

Address: Delta, Pa.

19. 1/19 (Date rec'd by registrar) 19 45 Registrar

Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 19 45 at 9:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 19 45, to January 19 19 45 and that I last saw him alive on January 19 19 45

Immediate cause of death	DURATION
Right lower lobe pneumonia	5 days
Due to: Cardiac decompensation, right	Indef.
Due to: Arteriosclerotic cardio-vascular disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Balto.-28, Md. Date signed 1/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-C

CERTIFICATE OF DEATH

64-154

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Balto.

City or town: Carney (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: Summit Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Carney (If outside city or town limits, write RURAL and give nearest town)

Street No.: Summit Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Abraham Bell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Anck Bell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29th 1878

8. AGE: Years	Months	Days	If less than one day
66	7	2	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Contractors Supplies

FATHER — 12. Name: Samuel Bell

FATHER — 13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Emily P. Bradley

MOTHER — 15. Birthplace: Balto. Md.

16. Informant: Mr. A. Bell

Address: Summit Ave. Carney

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/3/45- (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto. Md.

16. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd

19. 2/3/45- (Date rec'd by registrar) 19.. W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31st 1945, at 3:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1937, to Jan. 31 1945

and that I last saw h... alive on Jan 31 1945

Immediate cause of death: Carcinoma of the thyroid & metastases generalized — DURATION: July 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Dolesi M. D. (M. D. or other)

Address: 621 Hanford Rd Date signed: 2/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

06155 P

CERTIFICATE OF DEATH

Reg. Dist. No. X 2

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1504 Sulphur Spring Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George J. Berger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Catherine C. Berger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 4th 1885

8. AGE: Years	Months	Days	If less than one day
59	5	8	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: U.S. Printing & Lith. Company
FATHER 12. Name: John D. Berger
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Maryland
16. Informant: Mrs. Catherine C. Berger
Address: 1504 Sulphur Spring Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/1945 (month) (day) (year)
Cemetery or crematory: London Park Cem.
Location: 3801 Frederick Road
18. Funeral director: John J. Cowan & Son
Address: 901-03 Hollins Street
19. 1/13 1945 A. W. Hedrick Reg'd. M. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12th 1945 at 10:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1943 to Jan 12 1945
and that I last saw h... alive on Jan 12 1945

Immediate cause of death	DURATION
Apoplexy	1 day
Due to: Ch. Myocarditis with Hypertension	14 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard Larson M. D.
M. D. or other
Address: Hyattsville Date signed: Jan 13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

00156

Reg. Diat. No. 37

1. PLACE OF DEATH:
County: Balto
City or town: Putty Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place ef death?
Hospital, Institution, er street address where death occurred: 3001 Edgewood Rd
How long in hospital er institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Putty Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3001 Edgewood Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Bernhard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Della Bernhard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 17th 1865

8. AGE: Years	Months	Days	If less than one day
79	5	26	..... hrs. ..... min.

9. Birthplace: Harrisburg Pa.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry er business
FATHER 12. Name: Lazarus Bernhard
13. Birthplace: Germany
MOTHER 14. Maiden name: Barbara (Unknown)
15. Birthplace: "
16. Informaot: Della Bernhard
Address 3001 Edgewood Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/45 (month) (day) (year).
Cemetery ~~or crematory~~: Hebrew Friendship
Locatiee: Balto. Md.
18. Funeral director: William Cook Inc
Address: 127 St. Paul St
19. 1/16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13th 1945 at 7-45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 28 1944 to Jan 13 1945
and that I last saw h... alive on Jan 13 1945

Immediate cause of death	DURATION
Carcinoma of the stomach	Years
Due to Generalized arteriosclerosis,	
Due to far advanced	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of ep.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due te external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D.
M. D. or other
Address 6213 Harford Rd Date signed 1/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No G92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 18-E

Reg. Dist. No. 32

00157

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County: Baltimore

(b) City or town: Reisterstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Ret. Pleasant Sanatorium

(d) Length of stay in hospital or inst. (yrs., mos., or days): 9 mo.

(e) Length of stay in thie community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Maryland (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 15 E. Washington St (If rural give location)

(e) If foreign born, how long in U. S. A.? 33 years

3 (a) **FULL NAME**: Samuel Bernstein

3 (b) If veteran, name war:

3 (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Fannie Bernstein

6. (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): August 15, 1871

8. AGE: Years: 73 74 | Months: 5 | Days: 1 | If less than one day: ____hr. ____min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER

12. Name: Solomon Bernstein

13. Birthplace: Poland

MOTHER

14. Maiden Name: Gertrude ?

15. Birthplace: Poland

16 (a) Informant: Fannie Bernstein

(b) Address: 15 E. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Int. Carmel

Location: Seaman Mill Rd

18 (a) Funeral director: Jack Lewis Inc

(b) Address: 1439 E Baltimore St

19 (a) 1-16-45 (Date rec'd by registrar) (b) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. Date of death: January 16, 1945, at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to Jan. 16, 1945, and that I last saw him alive on Jan 16, 1945

Immediate cause of death	Duration
Myocardial Collapse	
Due to Pulmonary Tuberculosis	1 year
Due to Tuberculous Enteritis	1 month
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Albert D. Ahrens M.D. (M. D. or other)

Address: Reisterstown, Md. Date signed: Jan. 16, 1945.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

[redacted] Registered No. [redacted]

00158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5927 Marnat Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5927 Marnat Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AMY KAUFMANN BLACK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Max S. Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1887

8. AGE: Years	Months	Days	If less than one day
57	7	1	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Kaufmann
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Koch
15. Birthplace N. Y.

16 (a) Informant Mrs. James Kaufmann
(b) Address 3611 Labyrinth Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 2 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945, at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1943, to 1/1 1945, and that I last saw her alive on 1/1 1945

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Carcinoma of lung & liver (metastatic)	10 month
Due to Carcinoma of breast	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 4004 Liberty Hgts Ave Date signed 1/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Mr. Frank Levinson — 4004 Lib. Hgts.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06159

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7815 Ordmore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Mrs. Emma Elizabeth Bloom

3. (b) Social Security Number —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Thomas Gorsuch Bloom
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 15-1862
8. AGE: Years 82 Months 4 Days 3 If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Co. Maryland (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: William Plowman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Kelly
15. Birthplace: Maryland
16. Informant: Mrs. Emma E. Machen
Address: 7815 Ordmore Ave. Parkville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22-1945 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Maryland
18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road
19. 1/22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18- 1945, at 3 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1944 to Jan. 18 1945
and that I last saw h... alive on Jan. 17, 1945

	DURATION
Immediate cause of death: Generalized arteriosclerosis	1 yr.
Due to:	
Due to:	
Other conditions: Fractured left femur.	1 week.
Major [illegible]: Slipped & fell in own home.	

Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Harold A. Gratt, M.D. M. D. or other
Address 8100 Harford Rd. Date signed 1/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Harold Grott
8100 Harford Road
Ha 0125

Evidence for change of cause of death is shown on FILM No G 94 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54E)

CERTIFICATE OF DEATH

D 00160

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Raynor Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Raynor Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eugene LeRoy Bockman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 13, 1929

8. AGE: Years	Months	Days	If less than one day
15	9	24	hrs. min.

9. Birthplace Glenburnie, Md.
(Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER 12. Name Frederick G. Bockman

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Ida Goodrich

15. Birthplace Baltimore, Md.

16. Informant Mrs. Ida Heffler

Address Central ave. Raynor Hghts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10 1945 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore, Md.

18. Funeral director Frederick A. Cole

Address 1200 W. Lombard St

19. 1/10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1945, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to 19...

and that I last saw h... alive on 19...

Immediate cause of death	DURATION
Brain tumor, malignant. Cause A.	2 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bale Jr. M. D. or other

Address Linthicum Date signed 1-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00161

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Hrs.

Hospital, institution, or street address where death occurred:
Vets.Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 13 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1459 Stevenson St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3.(a) FULL NAME: IRVIN BONEBRAKE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Bonebrake

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 11-28-98

8. AGE: Years	Months	Days	If less than one day
46	1	19	...hrs. ...min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Driller

11. Industry or business:

FATHER — 12. Name: John Bonebrake

13. Birthplace: ?

MOTHER — 14. Maiden name: Susan ?

15. Birthplace: ?

16. Informant: Clinical Records, Vets.Adm.Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1/20/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: CHAS. L. STEVENS successor CHAS. Dill Undertaker

Address: 1501 E. Fort Ave., Balto., Md.

19. 1/20/45 (Date rec'd by registrar) C.W. Hedrick per M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 1945 at 4:05 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16, 1945, to January 17, 1945, and that I last saw him alive on January 17, 1945

Immediate cause of death	DURATION
Pneumonia Right Lobar	6 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: C.A. Kenney M. D. or other

C.A. KENNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Md. Date signed 1-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
1/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

66162

Reg. Dist. No. 30

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Leonardtown (If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: Anna May Boyd

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 2, 1889

8. AGE: Years	Months	Days	If less than one day
56	-	6	..... hrs. ..... min.

9. Birthplace: Leonardtown, Maryland (Town, county, and state)

10. Usual occupation: housekeeper

11. Industry or business: Rooming house

FATHER 12. Name: Thomas Boyd

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Margaret Ellen Camelier

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-45 (month) (day) (year)

Cemetery or crematory: St. Aloysius

Location: Leonardtown, Md.

18. Funeral director: W. C. Mattingley Sons

Address: Leonardtown, Md.

19. 1/8 (Date rec'd by registrar) 19 45 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1945, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11, 1944 to Jan. 8, 1945 and that I last saw h...er alive on Jan. 8, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to: Hypertensive cardiovascular disease	Before 12/11/44
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. E. Gardner M.D. M. D. or other

Robert E. Gardner, M.D.

Address: Baltimore - 28, Md. Date signed 1/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

P 00163

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1-½ Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 1-½ Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 900 Linden Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CHARLES H. BOYER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: ////

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-4-84

8. AGE: Years	Months	Days	If less than one day
60	6	14	..... hrs. ..... min.

9. Birthplace: Missouri
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Charles H. Boyer
13. Birthplace: Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-45 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder

Address: 4644 York Road., Balto. Md.

19. 1/23 45 (Date rec'd by registrar) Accepted (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1945, to Jan. 18, 1945 and that I last saw h... alive on January 18, 1945

Immediate cause of death	DURATION
Cirrhosis of Liver with ascites	Unknown
Due to	
Due to	
Other conditions: Pleurisy chr. fibrous right base	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: RME C. J. KENNEY, M. D. CLINICAL DIRECTOR M.D. or other

Address: Fort Howard, Maryland Date signed 1-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00164

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 7 mos., 1 day

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 7 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4724 York Rd., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles J. Brady

3.(b) Social Security Number: No. Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1914

8. AGE: Years	Months	Days	If less than one day
30	7	26	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Charles Jacob Brady

13. Birthplace: Brucetown, Virginia

MOTHER — 14. Maiden name: Catherine Mooney

15. Birthplace: Baltimore, Maryland

16. Informant: Charles J. Brady

Address: 4724 York Rd., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 1945 (month) (day) (year)

Cemetery or crematory: Mount Hebron Cemetery

Location: Winchester, Virginia

18. Funeral director: A.s. Lee Oder

Address: 4644 York Rd., Balto., Md.

19. 1/10/45 19 45 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the dale above stated; that I attended deceased from June 9, 1944 to Jan. 10, 1945 and that I last saw him alive on January 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs. 7 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart L. Shaffer M.D.
M. D. or other

Address: Mount Wilson, Md. Date signed: 1/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore 131-04

00166

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Balto
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 302 Hilton ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Howard
City or town Marriottsville (If outside city or town limits, write RURAL and give nearest town)
Street No. Old Fred. Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clarence E. Brickley Sr.
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary E. Wilson
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Sept 22 1872

8. AGE: Years 72 Months 3 Days 10 If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business retired
FATHER 12. Name Geo Brickley
13. Birthplace Md
MOTHER 14. Maiden name Emily Brown
15. Birthplace Md
16. Informant C. E. Brickley Jr
Address Marriottsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-1945 (month) (day) (year)
Cemetery or crematory Moreland Memorial Park
Location Balto. Md
18. Funeral director F. C. Heginbotham
Address Ellicott City Md
19. 1/10 1945 (Date rec'd by registrar) [signature] Registrar
Deputy Local.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 10 1945, at 1-15P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary occlusion	
Due to Cardio vascular	
Due to renal disease	
Other conditions Sudden death Inquiry (Include pregnancy within 3 months of death)	

Major findings of operations
..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Geo. F. McKieffer [illegible] M. D. or other
Address 1010 Leeds av Date signed 1-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

P 00165 38

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Black & Decker Co., Joppa Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 537 Alleghany Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James R. Britton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife Sarah E. Britton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	7	..... hrs. ..... min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual occupation Foreman
11. Industry or business Black & Decker
FATHER 12. Name Richard N. Britton
13. Birthplace Harford Co.
MOTHER 14. Maiden name Mary Smith
15. Birthplace N. Y.
16. Informant Mrs. Ida May Chilcoat
Address 537 W. Alleghany Ave., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/45 (month) (day) (year)
Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.
18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.
19. M 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1945 at 1.53 P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.... to ..... 19....
~~and that I last saw h.....~~ alive on ..... 19....

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. O. Mackey M.D.
M. D. or other
Address Towson Md. Date signed January 24 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 00167 30

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
642 Coleraine Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 642 Coleraine Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MANIE E. BRYANT

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph R. Bryant
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	23	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jesse Burroughs
13. Birthplace: Va.

MOTHER
14. Maiden name: Ann McKenney
15. Birthplace: Va

16. Informant: Miss Ruth Bryant
Address: 642 Coleraine Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/16 19 45 [signature] Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March, 26, 41 to Jan, 15 45
and that I last saw h er alive on Jan, 15 45

Immediate cause of death	DURATION
Cerebral Hemorrhage.	5 days
Due to: Arterial Hypertension	4 yrs
Due to:	
Other conditions: Chr. Myocardial Degenera tion.....	4 years

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op.
Autopsy results: 0
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: 0 Date of
Where did injury occur? 0 (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. Lloyd Johnson M. D. or other
Address: Catonsville, Md Date signed: Jan, 16, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

00168

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:
County: Balto.
City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4015 Walnut Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Marion V Bujac

3.(b) Social Security Number: 214-12-0559

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Bujac
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24 th 1902

8. AGE: Years	Months	Days	If less than one day
42	10	19	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Charwoman
11. Industry or business
12. FATHER — Name: James Dobson
13. FATHER — Birthplace:
14. MOTHER — Maiden name: Lenore D. Burton
15. MOTHER — Birthplace:
16. Informant: Family Records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 16 45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md.
18. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Rd
19. 1/15 19 45 Mrs. Ida Finty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 th 1945, at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 22 1943, to Jan 12 1945
and that I last saw h.. alive on Jan 11 th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs
Due to: Hypertension	24 yrs.
Due to: Nephritis	24 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Edward Bacon, M. D. or other
Address: 1 W. Overlea Ave. Date signed: 1/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

00169

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-14

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5704 Birchwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary A. Bursick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John R. Bursick

6.(c) If alive, give age: ~~68~~ 64 years

7. Birth date of deceased (mo., day, yr.): January 3, ~~1895~~ 1884

8. AGE: Years: 60 | Months: — | Days: 21 | If less than one day: ...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Patrick Tierney

FATHER — 13. Birthplace: ~~Ireland~~ Canada

MOTHER — 14. Maiden name: Catherine Gildea

MOTHER — 15. Birthplace: Ireland

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 24 45 (month) (day) (year)

Cemetery or crematory: Cathedral

Location:

18. Funeral director: L. J. Ruck

Address: 5305 Hartford Rd.

19. 1/25 19 45 A. W. Wedrick Deputy Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 19 45, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Bronchopneumonia	
Due to: Fracture of right femur, external condyle	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: January 12-45

Where did injury occur? Catonsville (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?): Roadside

Means of injury: Fall (unknown) Injured at work? no

23. SIGNATURE: G. McKieffer Endorsed Deputy M. D. or other

Address: 1010 Leadenhall Date signed: 1-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (925)

00170

CERTIFICATE OF DEATH

Reg. Dist. No. 442

1. PLACE OF DEATH:

County Baltimore

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs

Hospital, Institution, or street address where death occurred:

5535 oregon ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore Co.

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5535 oregon ave

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Helen Veronica Burton

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Roy Burton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15, 1900

8. AGE: Years	Months	Days	If less than one day
44	7	11	..... hrs. ..... min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual occupation housewife

11. Industry or business Home

FATHER 12. Name Anthony Truffin

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Ellen Jarden

15. Birthplace Baltimore Md

16. Informant Mrs. E. Elliott (aunt)

Address 1035 oregon Halethorpe Md

17. BURIAL (Burial, ~~cremation~~, or ~~removal~~. Which?) Date thereof JAN 31-45 (month) (day) (year)

Cemetery or crematory NEW CATHEDRAL.

Location BALTO., MD

18. Funeral director JOHN R KENNY

Address 1242 LEGDSTER. HALETHROPE MD.

19. Jan 30 19 44 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 45 at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Jan 26 19 45

and that I last saw her alive on Jan 25 19 45

Immediate cause of death	DURATION
Chr. Myocarditis	2 yrs.
Due to Decompensation	1 yrs.
Due to Mitral Stenosis & Cardiac Hypertrophy	10 yrs
Due to Arterial Hypertension	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation none Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. J. Brumbaugh M. D. or other

Address 1 Edmondson Ave Date signed 1/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00171

CERTIFICATE OF DEATH

Reg. Dist. No. 4-4

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1 Elkton, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: RICHARD CANNON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. Cannon

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 11-1-88

8. AGE:	Years	Months	Days	If less than one day
	56	2	10	...hrs. ...min.

9. Birthplace: Elkton, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Mark Cannon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary L. Reynolds
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan. 14, 1945 (month) (day) (year)

Cemetery or crematory: Elkton Cemetery
Location: Elkton, Maryland

18. Funeral director: H. W. Pippin & Son
Address: Elkton, Maryland

19. 1/12/ 19 45 (Date rec'd by registrar) J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11, 19 45, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2, 19 45, to Jan. 11, 19 45 and that I last saw him alive on Jan. 11, 19 45

Immediate cause of death	DURATION
Brain Tumor, benign cw.o.	Unknown
Due to Duration, unknown; symptomatic seven weeks cw.o.	
Due to	

Other conditions: Deafness, bilat. with timnitus, Aurium, Bilat., Audition right ea[illegible]
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: rmc. C. J. Kenney M. D. or other
C. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 1-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0172

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Balto
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, ~~Institution, or~~ street address where death occurred:
637 Register Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 637 Register Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Chas Henry Clark

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband or~~ wife: Lucy Clark
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 14th 1859

8. AGE:

Years	Months	Days	If less than one day
85	3	15	..... hrs. ..... min.

9. Birthplace: Waynesboro Va.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Carpenter & Builder
FATHER 12. Name: Unknown Clark
13. Birthplace "
MOTHER 14. Maiden name "
15. Birthplace "
16. Informant: Mrs Helen C. Potter
Address: 637 Register Ave-Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/45 (month) (day) (year)
Cemetery or ~~crematory~~: Druid Ridge
Location: Pikesville Md.
16. Funeral director: William Cook Inc.
Address: 1217 E. Read St.
19. 1/31/45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 29 19 45, at 7 M
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Accidental	
Due to: Asphyxiation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. D. C. Mackenzie M D
M. D., or other
Address: Pikesville Md Date signed Jany 29 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-C

CERTIFICATE OF DEATH

P 00173

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 51 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Harden Court
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: THOMAS COFFEE

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Hattie Coffee

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 8-9-94

8. AGE: Years	Months	Days	If less than one day
50	4	23	..... hrs. ..... min.

9. Birthplace: Florida
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Rubin Coffee
13. Birthplace: Florida

MOTHER — 14. Maiden name: Annie Washington
15. Birthplace: Florida

18. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 1/4 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1945, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12, 1944, to January 2, 1945 and that I last saw him alive on January 2, 1945

Immediate cause of death	DURATION
Bilateral Broncho-Pneumonia	6 Mos/ Plus
Due to: Esophageal tracheal fistula	
Due to: Bronchogenic Carcinoma	
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Palliative Gastrostomy
Date of op. 12-29-44

Autopsy results: Bronchogenic Carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Kenney

C. KENNEY, M.D. CLINICAL DIRECTOR (M. D. or other)

Address: Fort Howard, Md. Date signed: 1-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-m)

00174

CERTIFICATE OF DEATH

Reg. Dist. No. 461

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Fort Howard, Maryland

How long in hospital or institution? 39 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Petersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Hamilton Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME

COGLE, Charlie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-8-87

8. AGE: Years	Months	Days	If less than one day
57	5	4	hrs. min.

9. Birthplace: Prince George Co., Va.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: John Cogle
13. Birthplace: Virginia

MOTHER
14. Maiden name: Emma Davis
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-45 (month) (day) (year)

Cemetery or crematory:

Location: Petersburg Va

18. Funeral director: C. Lee Olden

Address: 4644 York Rd.

19. 1/13/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1945, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1944, to January 13, 1945, and that I last saw h... in life on January 13, 1945.

Immediate cause of death	DURATION
Heart Disease	
Coronary arteriosclerosis with	6 Weeks
Myocardial Insufficiency	Plus
Due to:	
Due to:	
Other conditions: Bronchitis, chr., asthmatic type; Pulmonary emphysema; Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

C. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 1-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00175

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore-28, Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 19 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 West 24th Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Cook

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Isabella Ellis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1868

8. AGE: Years	Months	Days	If less than one day
76	9	18	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Watch-maker

11. Industry or business: Watch

FATHER 12. Name: Henry B. Cook

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Henrietta Day

MOTHER 15. Birthplace: Virginia

18. Informant: Hospital records

Address: Baltimore-28, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 3, 45 (month) (day) (year)

Cemetery or crematory: Meadowridge Cem.

Location: Hamm's Co

18. Funeral director: Ambrose Inc

Address: 414 Frankfurtown Rd.

19. 2/1 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 19 45 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 19 44, to January 31 19 45

and that I last saw him alive on January 31 19 45

Immediate cause of death	DURATION
Broncho pneumonia	1 day
Due to: Chronic myocarditis	Indefinite
Due to: Chronic interstitial nephritis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 1/31/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

(M)

00176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 315 Ingleside Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 315 Ingleside Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: N

3. (a) FULL NAME: Mary C. Coulbourne

3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband ~~or wife~~: William T. Coulbourne
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb 22nd 1866

8. AGE: Years	Months	Days	If less than one day
78	10	21	... hrs. ... min.

9. Birthplace: Catonsville Md.
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Alfred Clayton
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Coulbourne
15. Birthplace: Md.

16. Informant: James Joyner
Address: New York N.Y.

17. Burial — Date thereof: 1/16/45
(Burial, ~~cremation or removal~~ ~~Which~~) (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Balto. Co. Md.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 1/13 1945 [signature] Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1945, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1944, to Jan 13 1945
and that I last saw h**er** alive on Jan 13 1945

Immediate cause of death: Arteriosclerotic cardio-vascular heart disease — DURATION: ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [signature], M.D.
M. D. or other
Address: Ellicott City Md. Date signed: 1/13/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00177

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac Howard Crowther

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary (Nee Chilcoat)

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1858 6.(c) If alive, give age 86 years

Mary (Nee Chilcoat)

8. AGE:

Years	Months	Days	If less than one day
86	11	4	hrs. min.

9. Birthplace: Sparks, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Isaac Crowther

13. Birthplace: Balto. Co., Md.

MOTHER

14. Maiden name: Mary Gregory

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. J. D. Tiedmi, Jr.

Address: Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15, 1945 (month) (day) (year)

Cemetery or crematory: Black Rock

Location: Balto. Co., Md.

18. Funeral director: Landon M. Bowles

Address: Sparks, Md

19. 1/14 45 (Date rec'd by registrar) Elmer C. Enzor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1945, at 2:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1945, to January 13 1945 and that I last saw h[illegible] alive on January 13 1945

Immediate cause of death	DURATION
Lobar Pneumonia	1 wk
Due to	
Due to	
Other conditions Chronic Myocarditis	9

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J. J. de Quesada Injured at work?

23. SIGNATURE T. G. de Quesada, M.D. M. D. or other

Address Towson 4, Md Date signed 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178a

CERTIFICATE OF DEATH

00178 Reg. Diat. No. 90

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: Edmondson Ave & Dutton Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edmondson Ave & Dutton Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary E Diehlmann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Rudolph G.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5 1872

8. AGE: Years	Months	Days	If less than one day
72	7	23	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation None
11. Industry or business
12. Name of FATHER Anthony Messmer
13. Birthplace Maryland
14. Maiden name of MOTHER Rosetta Dutton
15. Birthplace France
16. Informant Fred Diehlmann
Address Dutton Court Catons. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-31-1945 (month) (day) (year)
Cemetery or crematory Calvert
Location Baltimore Md
18. Funeral director George A Farley
Address Catonsville Md.
19. 1-31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at about 7 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxiation	
Due to Illuminating gas	
Due to accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Jan 28 45
Where did injury occur? Catonsville Baltimore Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Gas from stove Injured at work? no

23. SIGNATURE Geo McLeffen Asst Med Exam Balto
M. D. or other
Address 1010 Leadenhall Date signed 1-28-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

00179

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years, 9 mos., 14 das.

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 46 years, 9 mos., 14 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Lee Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1863?

8. AGE: Years: 81 | Months: ? | Days: ? | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Caleb O. Dorsey

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-20-45 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 1/20 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 19 45, at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 21, 1898 ~~XX~~ to January 4 19 45 and that I last saw him alive on January 4 19 45

Immediate cause of death	DURATION
Amaurosis	10 yrs.
Due to: Coronary occlusion	1 hour
Due to: Generalized arteriosclerosis Hypertensive cardiovascular	Indefinite
Other conditions: disease.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 1/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00180

CERTIFICATE OF DEATH

Reg. Diat. No. 97

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months

Hospital, Institution, or street address where death occurred: Masonic Home

How long in hospital or institution? 4 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Baltimore Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maria Louisa Birrot Durall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife Andrew J. Durall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25 - 1861

8. AGE:

Years	Months	Days	If less than one day
83	7	25	..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Henry Hilbert

13. Birthplace Baltimore Md

MOTHER

14. Maiden name Georgeana Stone

15. Birthplace Baltimore

18. Informant Laura M. Schneider

Address Masonic Home Cockeysville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan - 23 - 45 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Baltimore Md.

18. Funeral director Geo. L. Boyer, Jr.

Address 1512 Hollins St.

19. Jan. 22 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1945, to Jan 20 1945 and that I last saw h.. alive on Jan 20 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	11 days
Due to: Hypertensive Cardio	
Due to: Vascular disease	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Solomon Sherman M. D. or other

Address 2424 Entaw Parkway Date signed 1/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00181

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infante give residonce of mother)

State Md. County Balto.

City or town Reisterstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillian A. Dyer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Francis P. Dyer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1876

8. AGE: Years	Months	Days	If less than one day
68	3	29	hrs. min.

9. Birthplace Layuta N.Y. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jerome Reynolds

13. Birthplace N.Y.

MOTHER 14. Maiden name Elizabeth Lourdsberry

15. Birthplace N.Y.

16. Informant Jerome F. Dyer

Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1945 (month) (day) (year)

Cemetery or crematory Layuta Cem

Location Layuta N. Y.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Jan 16 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9, 1941, to Jan. 14, 1945 and that I last saw her alive on January 13, 1945

Immediate cause of death	DURATION
Coronary occlusion	
Due to Arteriosclerosis and Hypertension	4 years or more
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please nnderline the cause to which death should ho charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Walter Landau, M. D. M. D. or other

Address Reisterstown, Md. Date signed 1-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

00182 P

Reg. Diat. No. 31

1. PLACE OF DEATH:
County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
2003 Alta Vista Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2003 Alta Vista Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: DAVID GRAY ELDERKIN, SR.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Witte Elderkin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	23	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Weil & Scott Auto Co.

FATHER
12. Name: David G. Elderkin
13. Birthplace: Md.

MOTHER
14. Maiden name: Bessie Gettinger
15. Birthplace: Md.

16. Informant: Mr. Clarence E. Elderkin
Address: 210 E. Highfield Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/45 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 2/1 (Date rec'd by registrar) 19 45 A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30, 19 45 at 4:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 44 to Jan 29 19 45 and that I last saw h. l. alive on Jan 29 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	7 months
Due to: arteriosclerosis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William J. Sullivan M. D. or other
Address: 11 E. Chase St Date signed: Jan 31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

R 00183

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs., 1 month, 6 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 55 yrs., 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 148 Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George William Engel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
83	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: "

FATHER

12. Name: "

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Hospital records

Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31. 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Ave

18. Funeral director: Wm. Jno. John W. Teufel & Son

Address: 801 W. Fayette St.

19. 1 31 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29 1945, at 1:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pneumonia	
Due to fractured right femur	
Due to accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Jan 29 45

Where did injury occur? Catonsville Baltimore Md

(City or town) (County) (State)

Injured at home, farm, industry public place (where?): Hospital

Means of injury: Knocked down by an impatient Injured at work?

23. SIGNATURE: Geo. Wm. Engel Dept. Mental Hygiene

M. D. or other

Address: 1010 Leeds Ave Date signed: 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

P 00184

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Md.
How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1736 Duncan St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: GORDON ERDMAN

3. (b) Social Security Number: 214-01-8394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 9-26-04

8. AGE: Years	Months	Days	If less than one day
40	4	1	..... hrs. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: School Board
11. Industry or business
FATHER 12. Name: John T. Erdman
13. Birthplace: Balto., Md.
MOTHER 14. Maiden name: May Baird
15. Birthplace: Balto., Md.
16. Informant: Clinical Records, Vets., Adm. Facility
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.
18. Funeral director: Wm. Cook & Undertaker
Address: St. Paul & Preston Sts. Balto. Md.
19. 1/31 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28, 1945, at 9:50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1945, to January 28, 1945 and that I last saw him alive on January 28, 1945

Immediate cause of death	DURATION
Carcinoma of the Stomach with metastases to abdominal lymph nodes	Unknown
Due to:- pericardium and crest wall	
Due to	
Other conditions: Chr. Pul. Tuberculosis far adv. active	

(Include pregnancy within 3 months of death)

Major findings of operation: none ..... Date of op. .....
Autopsy results: As Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? Mil

23. SIGNATURE: C.J. Kenney
C.J. KENNEY, M.D. CLINICAL DIRECTOR, M. D. or other
Address: Fort Howard, Maryland Date signed 1-29-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00185

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 91 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 91 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Warren Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: GEORGE EVANS

3. (b) Social Security Number: 220-24-0359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lohmie Evans

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): February 22, ~~1894~~ 1890

8. AGE: Years	Months	Days	If less than one day
54	10	17	..... hrs. ..... min.

8. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Frank Evans

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Mamie ?

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 12 45 (month) (day) (year)

Cemetery or crematory: Oaklawn Cemetery

Location: Baltimore, Maryland

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road., Balto., Md.

19. 1/10 1945 (Date rec'd by registrar) Mrs. G. A. Finty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1945, 8:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1944, to January 9, 1945 and that I last saw him alive on January 9, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv.	27 Yrs.
Due to	
Due to	
Other conditions: Carcinoma left lung	1 Year plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney M.D. or other

C. J. KENNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 1-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

00186 44

1. PLACE OF DEATH

County Baltimore — Registration Dist. No. 44

Village or City Sparrows Point — No. 814 9 St. — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where daath occurrad 60 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Priscilla Evans

(a) Residence: No. 814 9 Street — Sparrows Pt. Ward, Md.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	C	M

5a. If married, widowad, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and yaar) Apr 26 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	68	7	23	

OCCUPATION

8. Trade, profassion, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. H. Work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date dacaased last workad at this occupation (month and year)

11. Total tima (yaars) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Talbott Co

FATHER

13. NAME Albert Darnett

14. BIRTHPLACE (city or town) (State or country) md

MOTHER

15. MAIDEN NAME Hattie Dixon

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Charles D Evans
(Addrass) 814 9 St. Sparrows Pt

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Date 1-23, 1945

19. UNDERTAKER Sam'l M. Chase & Son
(Addrass) 638 N. Gilmor St

20. FILED 1/22, 1945 D.H. Kedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 20th (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended daceased from Dec 21st, 1944, to Jan 20th, 1945

I last saw h- alive on January 19th, 1945; daath is said to have occurred on the date stated above, at 7 A m.

Tha **PRINCIPAL CAUSE OF DEATH** and ralated causas of importance were as follows:

	Date of onset
Pneumo-Pneumonia	Jan 2-45

Othar **Contributory Causes** of importance:

Name of operation ____ Date of ____

What tast confirmed diagnosis? none Was there an autopsy? No

23. If daath was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? ____ Date of injury ____, 19____

Whera did injury occur? ____
(Specify city or town, county and State)

Specify whathar injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.

Mannar of injury ____

Nature of injury ____

24. Was disaase or injury in any way related to occupation of dacaased? no

If so, spacify ____

(Signad) J.T. Thomas M.D.

(Addrass) 107 N. Main St Dundalk Md

M

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

00187

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto —
City or town Sparrows Pt. - Md —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Turner Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 Oak st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sam. Little Evans.

3. (b) Social Security Number

4. Sex M
5. Color or race Bl.
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Pearl Evans
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 1, 1903
8. AGE: Years 42 Months Days If less than one day hrs. min.
9. Birthplace Suffolk, Va (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Samuel Evans
13. Birthplace Va.
MOTHER 14. Maiden name unknown
15. Birthplace "
16. Informant Pearl Evans
Address 125 Oak st. Turner, sta. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-45 (month) (day) (year)
Cemetery or crematory
Location Suffolk, Va
18. Funeral director Elroy O. Wilson
Address 1000 Brantley ave
19. 1/5 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1945, at 12 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	30 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. B. Davis M.D. Asst. Dep. Med. Examiner Balto. Co. M.D., or other.
Address Dundalk. 22 Md Date signed 1-2-45

Rec'd. U.S.
1/5/45

37

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164C)

00188

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Sparrows Point 19

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? P.O. Box 202

Hospital, institution, or street address where death occurred: Pleasure Island

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Sparrows Point 19

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pleasure Island

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edwin J. Eversman

3. (b) Social Security Number

4. Sex Male

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anne E. Eversman

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 4 - 1905

8. AGE: Years 39 Months 9 Days 13 If less than one day ... hrs. ... min.

9. Birthplace Burlington, Iowa (Town, county, and state)

10. Usual occupation Caretaker

11. Industry or business Pleasure Island

FATHER 12. Name Jacob Eversman

13. Birthplace Missouri

MOTHER 14. Maiden name Louise Schlock

15. Birthplace Penna

16. Informant Mrs. Anne E. Eversman

Address 1632 N. Fayette St. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20-45 (month) (day) (year)

Cemetery or crematory Lorraine Cemetery

Location Woodlawn, Md.

18. Funeral director Wm. Lamorean

Address 4510 Liberty Heights Ave.

19. Jan. 17 1945 (Date rec'd by registrar) Wm. S. Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 10:30 a.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death Gun shot wound in forehead -

Due to Fracture skull blown

Due to open

DURATION Immediate

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide suicide Date of 1/17/45

Where did injury occur? Pleasure Is. (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot Gun Injured at work? No

23. SIGNATURE J. McCarmick M.D. M. D. or other

Deputy Medical Examiner

Address Dundalk, Md. Date signed 1/17/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00189

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore Co
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48
Hospital, institution, or street address where death occurred: 122 Sanford ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 Sanford ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas M Fisher

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6 1873

8. AGE: Years	Months	Days	If less than one day
71	9	21	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Geo. J. Fisher

13. Birthplace Germany

MOTHER 14. Maiden name Mary E. Bennett

15. Birthplace Maryland

16. Informant Edith Fisher

Address Hillsdale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30/45 (month) (day) (year)

Cemetery or crematory St Johns

Location Edw J & Mac Nabb Md

18. Funeral director Edw J Mac Nabb

Address Catonsville Md

19. 4 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 27 1945, at 11-30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardio vascular disease	
Due to sudden death	
Other conditions Surgery	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo M. Kieffer Dep Med Exam Balto
M. D. or other

Address 1010 Leadenhall ave Date signed 1-27-45

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00190

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. Holly Neck Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Paul Foard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Elizabeth Foard Zahradka 6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov. 1st - 1902

8. AGE: Years	Months	Days	If less than one day
42	2	25	...hrs. ...min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Supt. of Cafeteria

11. Industry or business Glenn Martin Co.

FATHER 12. Name William Foard

FATHER 13. Birthplace Balto.

MOTHER 14. Maiden name Z

MOTHER 15. Birthplace Md.

16. Informant Mrs. Eliz. Foard

Address Middle River

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30-45 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Germany Hill Rd.

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex

19. Jan 24 1945 J. G. Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.

Address ...Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00191

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years, 4 mos., 13 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 28 years, 4 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1407 N. Gay St.

(If rural give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Edna France

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: John William France

6.(c) If ~~alive~~, give age: years

7. Birth date of deceased (mo., day, yr.): February 23, 1884

8. AGE:

Years	Months	Days	If less than one day
60	10	21	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: Charles L. Conegys

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emma K. Wharton

15. Birthplace: Maryland

16. Informant: Spring Grove State Hosp. Records

Address: Catonsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16. 1945 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore, Md

18. Funeral director: L. Howard Strong

Address: 3107 W. North Ave.

19. 1-16 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 19 45 at 7.18 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 16 to Jan. 13 19 45 and that I last saw h~~er~~ alive on January 13 19 45

Immediate cause of death	DURATION
Uremia	3 mos.
Due to: Chronic Interstitial Nephritis	indef.
Due to: Art Hypertension	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: Robert E. Gardner M. D.

M. D. or other

Address: Spring Grove State Hosp. Date signed: Jan. 13, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

00192

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 147 Days

Hospital, institution, or street address where death occurred: Vets.Adm.Facility, Ft. Howard, Md.

How long in hospital or institution? 147 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1425 Ellamont St., Balto., Md. (If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WILLIAM R. GETTIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethelyn Gettier

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 3-20-91

8. AGE: Years	Months	Days	If less than one day
53	9	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: C. P. A.

11. Industry or business: Miller Chemical Co.

FATHER — 12. Name: George W. Gettier

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Georgeann Browning

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets.Adm.Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)

Cemetery or crematory: Loudoun Park

Location: Baltimore, Maryland

18. Funeral director: Wm. J. Tickner & Sons

Address: Baltimore, Maryland

19. 1/12 19 45 L.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1945, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 17, 1944, to January 11, 1945 and that I last saw him alive on January 11, 1945

Immediate cause of death	DURATION
Hypertension Coronary arteriosclerotic (1 Yr.	
heart disease with cardiac hypertrophy plus)	
Due to: Myocardial damage and myocardial	
insufficiency	
Due to	
Other conditions: Retinal arteriosclerosis	
Hemiplegia left residuals of old	
cerebral hemorrhage.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? Nat

23. SIGNATURE: C.J. Kenney

C.J. KENNEY, M.D. CLINICAL DIRECTOR, M. D. or other

Address: Fort Howard, Maryland Date signed 1-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

00193

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ yrs Includes Edmondson ave
Hospital, institution, or street address where death occurred: Catonsville Nursing Home
How long in hospital or institution? 20 3 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5303 Falls Rd Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Grace Irene Gokey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: Charles F Gokey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30 1870

8. AGE: Years 74 | Months 6 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Newark City Ky.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Augustus Wheatley
13. Birthplace: Ky

MOTHER
14. Maiden name: Mary Hodges
15. Birthplace: Corydon Ky.

16. Informant: Mr. Federal P. Gokey
Address: 5303 Falls Rd. Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 — 27 1945, at 7-50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
acute Cardiac failure	
Gangrene of bilateral	
Due to Ulcers due to bed sores	
Ulcers sacrum	
Due to Cardio-renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: about
Accident, suicide, or homicide: Accident Date of: August 20, 1944
Where did injury occur? Catonsville Balto Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Fall on floor Injured at work? No

23. SIGNATURE: Geo. McCaffin Asst Med Exam Balto
M. D. or other
Address: 1010 Leeds ave Date signed 1-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00194 P

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore - 19 -
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R 10 Box 369.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: North Pt Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No.: North Pt Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ruth Goretsas.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife: William Goretsas. 6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): July 13, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	2	hrs. min.

9. Birthplace: Frederick. md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: own home.

FATHER
12. Name: Daniel Sykes.
13. Birthplace: England

MOTHER
14. Maiden name: Addie.
15. Birthplace: Frederick, Md

16. Informant: William Goretsas
Address: North Pt Road RT 10 - Box 369

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 19-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location:

18. Funeral director: Charles P Powell
Address: 2427 Edmondson Ave.

19. 1/17 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January. 15 1945, at 2:03 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938, to Jan. 15 1945. and that I last saw her alive on Jan. 14 1945.

Immediate cause of death	DURATION
Pulmonary oedema.	2 days.
Due to Cerebral Hemorrhage	5 days.
Due to Hypertensive Cardio Vascular disease.	7 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis N. Pullin. M.D. M. D. or other
Address: Sparrows Pt. md Date signed 1/15/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd U.S.
1/17/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

00195

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Bengies Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Bengies Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Helen Grabowski

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6.(a) Single, married, widowed, or divorced M.
6.(b) Name of husband or wife Unk.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 Months Days If less than one day ... hrs. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Farm hand
11. Industry or business

FATHER
12. Name Michael Lawicki
13. Birthplace Poland

MOTHER
14. Maiden name Mollie Nowicki
15. Birthplace Poland

16. Informant Michael Lawicki
Address 2217 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24/45 (month) (day) (year)
Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18. Funeral director Fred W Ozazewski
Address 1930 Eastern Ave.

19. 1/23 1945 (Date rec'd by registrar) Julius M. Mulsner Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1945, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from .... 19...., to .... 19....
and that I last saw h..... alive on .... 19....

Immediate cause of death Coronary Occlusion — DURATION 5-10 mi.

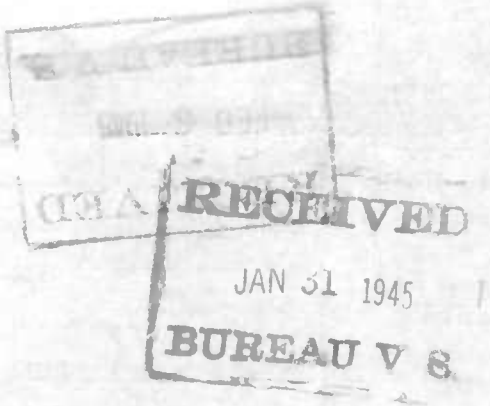
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Davis M.D. Asst. Dep. Med. Examiner Balto. Co. M.D. or other
Address Dundalk - 22 - Md. Date signed 1/23/45

W. Shlearmand Reg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M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9401)

CERTIFICATE OF DEATH

00196

Reg. Dist. No. 38

1. PLACE OF DEATH:

County 903 Wellington Road

City or town Stoneleigh , Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Wellington Road, Stoneleigh (If rural, give LOCATION)

2.(a) If veteran, name war W

3. (a) FULL NAME HENRY WALDO GRANT

3. (b) Social Security Number 070-07-4589

4. Sex Male | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife IRENE

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 29, 1891

8. AGE: Years	Months	Days	If less than one day
53	6	17	... hrs. ... min.

9. Birthplace Minnessota (Town, county, and state)

10. Usual occupation Sales Manager

11. Industry or business General Mills, Inc.

FATHER 12. Name Grant

13. Birthplace Boston

MOTHER 14. Maiden name Swallow

15. Birthplace Boston

16. Informant Mrs. Irene V. Grant

Address 903 Wellington Road

17. Burial (Burial, cremation, or removal, Which?) Date thereof January 20, 1945 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director William Cook, Incorporated

Address 1217 St. Paul Street, Baltimore

19. 1/17 1945 A. W. Hedrick per ... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 16 1945 at 9-20 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from ... 19... , to ... 19... and that I last saw h... alive on ... 19...~~

Immediate cause of death Coronary Thrombosis

DURATION

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. T. Fryer ... M. Ex. M. D. or other

Address Towsontown Md Date signed Jany 16 1945

Rec'd U.S.
1/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

P

00197 Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1408 E. Chase St., Balto., 13, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: Indian War

3. (a) FULL NAME: JOHN C. GREEN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: ////Jennie Green

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1859

8. AGE: Years	Months	Days	If less than one day
85	2	1	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER 12. Name: Alexander Green

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Harriett Wayman

MOTHER 15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Sanders Funeral Home

Address: 1412 E. Preston St., Balto., Md.

19. 1/20 45 (Date rec'd by registrar) A. M. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1945, at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1945, to January 17, 1945 and that I last saw him alive on January 17, 1945

Immediate cause of death	DURATION
HEART DISEASE	
Due to: Coronary arteriosclerosis with	Unknown
Due to: ////Myocardial Insufficiency.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. J. Kenney M. D. or other

Address: Ft. Howard, Maryland Date signed: 1-17-45

C. J. KENNEY, M. D. CLINICAL DIRECTOR

Rec'd U.S.
1/20/14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00198

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years, 10 months, 12 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 28 years, 10 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. Front Street
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME

Benjamin Grossman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years: 54 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER
12. Name: Hymen Grossman
13. Birthplace: Russia

MOTHER
14. Maiden name: ?
15. Birthplace: Russia

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-45 (month) (day) (year)

Cemetery or crematory: Hebrew Mt. Carmel

Location: Gerwan Hill Road

18. Funeral director: Jack Lewis Inc

Address: 1439 E Balto St

19. 1/13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 19 45, at 6-50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardiovascular disease	
Due to: sudden death	
Other conditions: Enquiry	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Geo. M. Kieffer Dep. Med Exam Balto Co
M. D. or other

Address: 910 Leeden ... Date signed 1-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

(0039)

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore

City or town Fullerton (Joppa Road)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Joppa Road

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Amelia J. Grunewald

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife Frederick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 2, 1859

8. AGE: Years	Months	Days	If less than one day
85	1	24	..... hrs. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Wm Robert Davis

13. Birthplace W. Va.

MOTHER 14. Maiden name Susan T. Grey

15. Birthplace Md.

16. Informant John H. Sandberg

Address Joppa Road, Fullerton, Md.

17. burial Date thereof Jan. 30 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Md.

18. Funeral director William Cook, Inc.

Address 1217 St. Paul Street

19. 1/27 19 45 A. W. Hedrick

(Date rec'd by registrar) M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 19 45 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1st 19 44, to Jan 26 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage & Hypertension	2 hrs.
Due to arteriosclerosis	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward Benson M. D. or other

Address 14 W. Preston Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G94 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (76)

CERTIFICATE OF DEATH

00290

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Fort Howard - Md.
City or town BALTO. COUNTY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Fort Howard Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Fullerton
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3722 Tutty Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war World War # 2

3.(a) FULL NAME MELVIN V. HAMMOND

3.(b) Social Security Number 217-14-6953

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	WHITE	Divorced

6.(b) Name of husband or wife Ruth B. Hammond
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July - 20 - 1922

8. AGE: Years 22 | Months 5 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual occupation Glen L. Martin Co.

11. Industry or business

FATHER
12. Name Ellwood Hammond
13. Birthplace Balto. Md.

MOTHER
14. Maiden name Lucille Rule
15. Birthplace Hagerstown Md.

16. Informant Edward Hammond
Address 3722 Tutty Hill Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 17 - 45 (month) (day) (year)
Cemetery or crematory Parkwood Mem.
Location Taylor Ave.

18. Funeral director John C. Miller Inc.
Address 2437 E. Oliver St.

19. 1/15 1945 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 14 1945, at 3 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.im alive on JANUARY 14th 1945

Immediate cause of death	DURATION
FRACTURE SPINE	
C Transverse Myelitis	
Due to Gun Shot Wound of Spine; Shot, while in armed forces, — Enemy World War II.	
Due to	
Other conditions Septicemia.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR M.D. or Other
Address Fort Howard, Md. Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.
1/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-d)

CERTIFICATE OF DEATH

00201

Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Masonic Home, Cockeysville

How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3727 Reisterstown Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Alice Elizabeth Hardy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 2 - 1872

8. AGE: Years	Months	Days	If less than one day
72	11	18	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Sales Lady

11. Industry or business:

FATHER — 12. Name: John W. Hardy

FATHER — 13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Mary A. Coleman

MOTHER — 15. Birthplace: Baltimore Md.

16. Informant: Laura M. Schneider

Address: Masonic Home, Cockeysville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan - 23 - 45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Baltimore Md

18. Funeral director: Geo. L. Beyer

Address: 1512 Hollins St

19. Jan. 22 19 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 19 45 at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 41 to Jan 20 19 45

and that I last saw her alive on Jan 20 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Hypertensive Cardio	
Due to Myocardial Disease	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Solomon Sherman M. D. or other

Address: 2424 Eutaw Place Date signed: 1/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

10 00202

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7722 Harford Road (14)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian M.L.Hartje

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William G.Hartje
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 10,1899

8. AGE: Years	Months	Days	If less than one day
45	1	24	..... hrs. ..... min.

9. Birthplace: Balto.Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Geo.F.Spangenberger
13. Birthplace: Balto.Md.

MOTHER
14. Maiden name: Minnie Ulrich
15. Birthplace: Germany

16. Informant: Wm.G.Hartje
Address: 7722 Harford Road (14)

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan.6th.1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Balto.Md.

18. Funeral director: Philip Herwig Sons
Address: 2024 Orleans St.Balto. 31 Md.

19. 1/5 45 (Date rec'd by registrar) C.W.Hedrick per D (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3rd.1945 19..... at 12.A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 2, 1945, to Jan. 3, 1945 and that I last saw h... alive on Jan. 3, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: H. a. grott M.D.
M. D. or other
Address: 8100 Harford Rd Date signed 1/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd. U.S.
1/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

00203

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 S. Stewart Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Barbara Hartman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Joseph Hartman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 2 - 1857

8. AGE: Years	Months	Days	If less than one day
87	5	17	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Louis Eckert
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. Catherine Good
Address: 110 S. Stewart Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22-45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Boulevard

18. Funeral director: Jno. G. Connelly
Address: 418 Eastern Ave. Essex

19. Jan. 22 1945 Jno. G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19th 1945, at 12:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1941, to Jan 19 1945 and that I last saw h.. alive on Jan 19 1945

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	2 yr.
Due to: Generalized Arteriosclerosis	5 yr.
Due to:	
Other conditions: Parkinsons Disease	5 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward M. Hummel M. D. or other
Address: Essex Md. Date signed: 1/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00204

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Pitcher St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JOSEPH W. HAWKINS

3.(b) Social Security Number: 216-09-0330

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 2-6-1895

8. AGE: Years	Months	Days	If less than one day
49	11	23	..... hrs. ..... min.

9. Birthplace: Calvert Co., Md.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business

FATHER
12. Name: Bernie Hawkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lula Digges
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2-1945 (month) (day) (year)

Cemetery or crematory: Balto National Cemetery

Location: Frederick Road Via Brooklyn Ruggles

18. Funeral director: [illegible]

Address: 1463 N. Carey St

19. 1/31 19.. (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1945, at 8:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1945, to January 30, 1945 and that I last saw him alive on January 30, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv. active	2 Yrs. plus.
Due to	
Due to	
Other conditions: Peripheral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE: C. J. KENNEY

C. J. KENNEY, M.D. CLINICAL DIRECTOR
M.D. or other

Address: Fort Howard, Maryland Date signed: 1-30-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (460) Reg. Dist. No. 45

CERTIFICATE OF DEATH

00205

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Baltimore 6, Rosedale. (If outside city or town limits, write RURAL and give town)
(c) Street address, ~~hospital, or institution~~: 7812 Philadelphia Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ____
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 6, Rosedale (If outside city or town limits, write RURAL and give town)
(d) Street No. 7812 Philadelphia Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** ERNEST W. HEINBUCH

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Anna E. Heinbuch
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) April 11th 1880
8. AGE: Years 64 Months 8 Days 29 If less than one day ____ hr. ____ min.
9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual occupation Florist
11. Industry or business Flower growing
12. FATHER Name Peter Heinbuch
13. FATHER Birthplace Germany
14. MOTHER Maiden Name Margaret Feist
15. MOTHER Birthplace Germany
16 (a) Informant Mrs. E. W. Heinbuch
16 (b) Address 7812 Phila. Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (month) 14 (day) 45 (year)
17 (c) Cemetery or crematory Zion Lutherans
Location Balto. Co. Md.
18 (a) Funeral director Loyola Funeral Home
18 (b) Address 7401 Belair Rd.
19 (a) 1/12/45 (Date rec'd by registrar) (b) Mrs. E. A. Fritz Registrar

MEDICAL CERTIFICATION

20. Date of death January 10 19 45, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1944, to Jan. 10 1945, and that I last saw him alive on Jan 10 1945.

Immediate cause of death	Duration
Pulmonary Haemorrhage.	
Due to Carcinoma of the esophagus	3 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Above confirmed
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey L. Tuller M.D. (M. D. or other)
Address Ridge Road, Balt-6 Md. Date signed 1/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00206

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dalethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dalethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1701 Sulphur Spring Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Ada Jane Henrickle

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Abel C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1863

8. AGE: Years	Months	Days	If less than one day
81	5	25	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Otis

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Susie Gunkinson

MOTHER — 15. Birthplace: Ohio

16. Informant: Frank J. Henrickle

Address: 1701 Sulphur Spring Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/9/45 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Baltimore Md

18. Funeral director: William Coe Inc

Address: 1217 E Fort Ave

19. 1/8/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 6 1945

and that I last saw her alive on Jan 5 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Paul Schofield M. D. or other

Address: 1301 Aisquith St Date signed: 1/6/45

Paul Schofield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00207

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs
Hospital, Institution, or street address where death occurred: Mace Ave. Essex
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
Street No. Mace Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William A. Hilmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen E. Hilmer
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 25th 1866

8. AGE: Years	Months	Days	If less than one day
78	3	18	hrs. min.

8. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Merchant
FATHER 12. Name Hilmer
13. Birthplace Germany
MOTHER 14. Maiden name
15. Birthplace
18. Informant Mrs. W.A. Hilmer
Address Mace Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 16 45 (month) (day) (year)
Cemetery or crematory Zion Lutheran
Location Balto. Co. Md
18. Funeral director Lasch-Timmerhaus
Address 7401 Belair Rd.
19. Jan 15 1945 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th 1945, at 12 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1945, to January 13 1945
and that I last saw h...alive on January 13 1945

	DURATION
Immediate cause of death	
Cerebral Hemorrhage	5 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. White, M.D. M. D. or other
Address 7601 Eastern Ave. Baltimore 24, Md. Date signed 1/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9402)

00208

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto —
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos
Hospital, institution, or street address where death occurred: Hood Nursing Home
How long in hospital or institution? 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George J. Hinder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna Hinder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1873.

8. AGE:

Years	Months	Days	If less than one day
71	11	4	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Geo Hinder
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth —
15. Birthplace: Md.

16. Informant: Miss Helen Hinder
Address: Long Green Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27-45 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Balto Co. Hoyard
18. Funeral director: Hornberger & Sons
Address: Dundalk Md.

19. 1/25/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1945, at 7.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1944, to Jan 25 1945 and that I last saw h.. alive on Jan 25 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Generalized Arteriosclerosis	1 yr.
Due to:	
Other conditions: Hyp. Tabes Depression	3 mos

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James J Stowell M. D. or other
Address: Catonsville Date signed: 1-25

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EVIDENCE for additions on items #7 and 8 shown on Film G92, 1-23-45. LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

00209 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
20 Seminole Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Seminole Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LYDIA VOGEL HORLEBEIN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank C. Horlebein
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	2	2	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Emil Vogel
13. Birthplace: Germany
MOTHER 14. Maiden name: Wilhelmina Brueggeman
15. Birthplace: Baltimore, Md.
16. Informant: Mr. Edwin W. Horlebein
Address: 20 Seminole Ave., Catonsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1945 (month) (day) (year)
Cemetery or crematory: St. Paul's Cem.
Location: Violetville, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 1/15 19 45 Accepted (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13, 45 9:30a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 44 to Jan 13 19 45 and that I last saw h.. alive on Jan 13 19

Immediate cause of death	DURATION
Cancer of Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Evans M. D. or other
Address: 612 N 40 at Date signed

Mr. John Evans. 612 21. 40th St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

P

00210 38
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Govans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Yrs.
Hospital, institution, or street address where death occurred:
Mercy Villa
How long in hospital or institution? 5 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bellona AvE.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary A. Horrigan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ****
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1853

8. AGE: Years: 91 Yrs. | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Cornelius Horrigan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary C. Dunworth
15. Birthplace: Ireland

16. Informant: Miss Catherine A. Saunders
Address: 333 North Charles St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2/45 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore, Md.

18. Funeral director: H. W. Means & Son
Address: 805 N. Calvert St.

19. 2/1 19 45 (Date rec'd by registrar) W. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30 19 44 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 19 44 to Jan 30 19 44
and that I last saw h.. alive on Jan 30 19 44

Immediate cause of death	DURATION
Cerebral Apoplexy.	1 week
Due to: Senile Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm J Schmit M. D. or other
Address: 701 N. Howard ave Date signed: 2/1/45

Rec'd U.S.
2/1/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00211

Reg. Dist. No. 238

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since January 17, 1945
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since January 17, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: University Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Reba Jane Huber

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Jack Huber
6.(c) If alive, give age: 22 years
7. Birth date of deceased (mo., day, yr.): October 24, 1926
8. AGE: Years: 18 Months: 3 Days: If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. FATHER — Name: Joshua Groves
13. FATHER — Birthplace: Virginia
14. MOTHER — Maiden name: Ella Jane Bird
15. MOTHER — Birthplace: Maryland
16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: 1-23-45 (month) (day) (year)
Cemetery or crematory:
Location: Riverdale Md.
18. Funeral director: W.W. Chambers Co.
Address: Riverdale Md.
19. (Date rec'd by registrar): Jan 23 1945 Registrar: W. Garrett Lankford Deputy Clerk

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1945 at 12 Noon M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 1945, to Jan 23 1945
and that I last saw h.r.l. alive on January 23 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	Indefinite
Due to:	Just
	Many
Due to:	Years
	I was
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M. D. or other
Address: Towson, 4, Maryland Date signed: 1-23-45

Howell
Catonsville, Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 00212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Co.
(b) Street address 5501 Edmondson Avenue
(c) Hospital or Institution Catonsville
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6306 Banyby Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ilgenfritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Martin L. Ilgenfritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Joseph Marshall
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. William D. Ilgenfritz
(b) Address 4710 Griddon Avenue (14)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road (14)

19 (a) 1-16-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1945, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to Jan 13 1945, and that I last saw h[illegible] alive on Jan 13 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arterio Sclerosis	2 yrs
Cardio Vas. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 1-15

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

00213

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Md.

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1419 E. Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: CHARLES JOHNSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Div.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1892

8. AGE: Years	Months	Days	If less than one day
52	7		..... hrs. ..... min.

9. Birthplace: Raleigh, N. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Will Johnson
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Dollie Freeman
15. Birthplace: North Carolina

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md. Rme

19. 2/5/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1945 at 1:45 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 30, 1945, to January 31, 1945 and that I last saw him alive on January 31, 1945

Immediate cause of death	DURATION
Diabetic Coma	20 Hrs.
	plus
Due to: Diabetes Mellitus	Unknown
Due to:	
Other conditions: Stricture, urethra severe	

(Include pregnancy within 3 months of death)

Major findings of operations: no Operations
Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

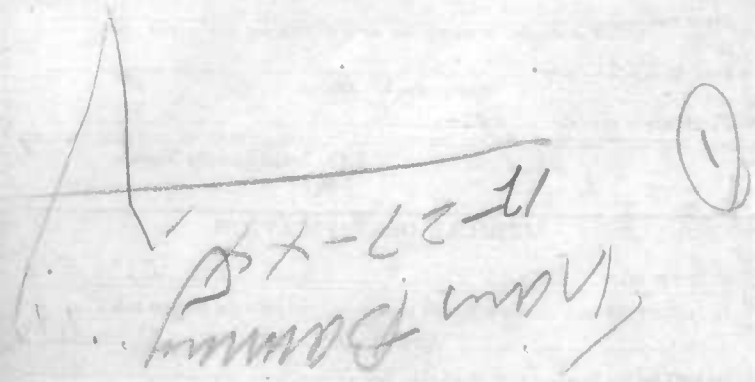
Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney
C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other
Address: Fort Howard, Md. Date signed 2-1-45



(41)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (H)

00214

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Hrs. 40 Minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Ft. Howard, Md.

How long in hospital or institution? 25 Hrs. 40 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1309 Myrtle Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3. (a) FULL NAME: JAMES H. JOHNSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): +1897 July 20, 1893

8. AGE: Years: 51 | Months: 6 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: James H. Johnson

FATHER — 13. Birthplace: ? Va.

MOTHER — 14. Maiden name: ? Sarah Holmes

MOTHER — 15. Birthplace: ? Va.

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-25-45 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cem

Location: Baltimore, Co., Md.

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St., Balto., Md.

19. Jan. 24 1945 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21, 1945 at 6:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20, 1945 to Jan. 21, 1945 and that I last saw him alive on Jan. 21, 1945

Immediate cause of death	DURATION
Disease of Heart	Unknown
Coronary Arteriosclerosis with	
Due to Myocardial Insufficiency	
Due to	
Due to	
Other conditions Uremia, acute, nephrosclerosis	
Diabetes, mellitus, amputation both legs, old	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. KENNEY, M. D. CLINICAL DIRECTOR M.D. or other

Address: Ft. Howard, Md. Date signed: 1-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00215

Reg. Dist. No. 38

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Carney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred: 9630 Mason Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: 9630 Mason Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carney

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alexander Jones

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Harriet P. Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 6 - 1861

8. AGE: Years: 83 | Months: 2 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~Prince George~~ St. Marys Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Watchman

11. Industry or business: McCormick & Co

FATHER — 12. Name: Grovner M. C. Jones

FATHER — 13. Birthplace: St. Marys Co.

MOTHER — 14. Maiden name: Angelita B. Patterson

MOTHER — 15. Birthplace: Unknown

16. Informant: William R. P. Jones

Address: 9630 Mason Ave - Carney

17. ~~Burial, cremation, or removal. Which?~~ Burial — Date thereof 1/26/45 (mouth) (day) (year)

Cemetery or ~~crematory~~: St. Marys

Location: St. Marys City, Md.

18. Funeral director: William Cox Inc

Address: 127 E. Paul St.

19. 1-23 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23rd 1945 at 3 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 37, to Jan. 23 1945 and that I last saw him alive on Jan. 21 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	4 days
Due to: Hypertension & Chronic myocarditis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Bacon M. D. (M. D. or other)

Address: 2810 Taylor Ave. Date signed: 1/23/45

added date of death from phone call from Dr. Warren - 2/27/45 CH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83rd)

CERTIFICATE OF DEATH

P 00216

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Armagh Village
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82 Years

Hospital, institution, or street address where death occurred:
7015 Bellona Avenue

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Armagh Village
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7015 Bellona Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war ---

3. (a) FULL NAME

Jane Kay Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John N. Jones

6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): December 12, 1862

8. AGE: Years 82 | Months 1 | Days 6 | If less than one day: -- hrs. --- min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ---

FATHER
12. Name: John Kay
13. Birthplace: Ireland

MOTHER
14. Maiden name: Not obtainable
15. Birthplace: England

16. Informant: Mrs. James L. McGraw
Address: 7015 Bellona Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/22/45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18. Funeral director: H. O. Mears and Son

Address: 805 N. Calvert Street

19. 1/20 1945 (Date rec'd by registrar) G. W. Hedrich per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 1945 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1- 1944 to 1-18 1945 and that I last saw h alive on 1-18- 1945

Immediate cause of death	DURATION
Due to: Cerebral hemorrhage.	36 h.
Due to: Hypertension	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Howard F. Warner M. D. ~~or other~~

Address: 1604 Garrison Blvd Date signed 1-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd U.S.
1/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

P-0217

Reg. Dist. No. 30

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? abt. 15 months

Hospital, institution, or street address where death occurred:

5313 Edmondson Ave.

How long in hospital or institution? abt. 15 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4219 Vermont Ave., Irvington,

(If rural, give LOCATION)

2.(a) If veteran, name war: NO

3. (a) FULL NAME: Edith L Virginia Kelley - (Kelley)

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John James Kelley

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	22	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business: NONE

FATHER

12. Name: Edward C. Yinger

13. Birthplace: Frederick, Maryland

MOTHER

14. Maiden name: Anna Rebecca Poole

15. Birthplace: Frederick Co., Md.

16. Informant: Mr. Walter L. Yinger - (brother)

Address: 4219 Vermont Ave., Irv., Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

16. Funeral director: Jos. Joerdens & Son

Address: 1907 Park Ave. - Balto. Md.

19. 1/12 1945 (Date rec'd by registrar) H.W. Helmich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1945 at 12 x m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 10 1945

and that I last saw h[illegible] alive on Jan 10 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Day
Due to Cerebral Arterio Sclerosis	1 Yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Date signed: 1-10-45

00218 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 1 month, 30 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 4 yrs., 1 month, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1308 Beason Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Kennedy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	18	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: James Kennedy

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Maria Armstrong

MOTHER — 15. Birthplace: Ireland

16. Informant: Hospital records

Address: Catonsville-28, Balto., Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)

Cemetery or crematory: Trinity-Evang. Lutheran

Location: 5500 O'Donnell St.

18. Funeral director: Howard N. Blight Jr.

Address: 4914 Belair Road

19. 1/15 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1945, at 2:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 1940, to January 12 1945 and that I last saw him alive on January 12 1945

Immediate cause of death	DURATION
Right terminal broncho pneumonia with pulmonary edema	72 hrs.
Due to: Generalized arteriosclerosis	Indef.
Due to: Adhesive pericarditis with hemopericardium with coronary	
Other conditions: sclerosis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville, Balto.-28, Md. Date signed 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

00219 P

Reg. Dist. No. 30

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mrs. Joanna Kennedy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: William

7. Birth date of deceased (mo., day, yr.): March 10, 1881

6.(c) If alive, give age: years

8. AGE:

Years	Months	Days	If less than one day
63	10	12	hrs. min.

9. Birthplace: Dorsey Md.

(Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER

12. Name: Samuel Dorsey

13. Birthplace: Dorsey Md.

MOTHER

14. Maiden name: Mary E. Williams

15. Birthplace: Dorsey Md.

16. Informant: Wilbur L. Dorsey

Address: 715 Bartlett Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/45 (month) (day) (year)

Cemetery or crematory: Western

Location: Edmondson Ave.

18. Funeral director: Wm. F. Porter

Address: 2836 W. North Ave.

19. 1/24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23 1945 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 18 1944 to Jan 23 1945 and that I last saw h alive on Jan 22 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Cerebral Hemorrhage	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. E. Campbell M. D. or other

Address: 16 x 4 Hanover St Date signed: 1/23/45

1644 Hanover 11

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83 2)

CERTIFICATE OF DEATH

D 111221

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1004½ Frederick Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County: Stafford

City or town: Fredericksburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---------- (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPHINE R. KERNS

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George W. Kerns

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	19	....hrs. ....min.

9. Birthplace: Gulpepper Co., Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Robert Green
13. Birthplace: Va.

MOTHER
14. Maiden name: Jane Bennett
15. Birthplace: Va.

16. Informant: Mrs. Edith H. Hickman, daughter
Address: 211 W. 27th St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/27/45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/26 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25, 1945, at 7A - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Jan 25 1945 and that I last saw her alive on Jan 24 1945

Immediate cause of death	DURATION
Cerebral Arterio Sclerosis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. J. G. Howell - 715 Frederick Ave., Catonsville

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18.

00221

CERTIFICATE OF DEATH

Reg. Dist. No. 9-38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 4 yr - 6 mo - 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 814 Mt. Hoch St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Patrick Kerr

3. (b) Social Security Number: 216-03-1762

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Clara F. Kerr
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec 30, 1880

8. AGE:

Years	Months	Days	If less than one day
64		3	hrs. min.

9. Birthplace: Maryland - Baltimore
(Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business

FATHER
12. Name: Edward Kerr
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Healy
15. Birthplace: Ireland

18. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium Towson 4, Md.

17. Burial, cremation, or removal (Which?) Burial — Date thereof (month) (day) (year): 4-4-45
Cemetery or crematory: Cathedral
Location: Baltimore Md.
18. Funeral director: George A. Fuchs
Address: Fuchs & Sappell

19. (Date rec'd by registrar) Jan 4, 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 19 45 at 4.20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 40, to Jan 2 19 45 and that I last saw h[illegible] alive on Jan 1 19 45

Immediate cause of death: Pulmonary T.B.

	DURATION
Due to:	7yr
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. G. Bridges M. D. or other
Address: Towson, Maryland Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

P 110222

Reg. Dist. No. 35

1. PLACE OF DEATH:

County .....

City or town Towson, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County .....

City or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1706 N. Bond St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME SELMA ANNA KLINK

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1857

8. AGE: Years	Months	Days	If less than one day
87	5		..... hrs. ..... min.

9. Birthplace Rhode Island (Town, county, and state)

10. Usual occupation At Home

11. Industry or business .....

FATHER — 12. Name George G. Klink

FATHER — 13. Birthplace Germany

MOTHER — 14. Maiden name unknown

MOTHER — 15. Birthplace "

16. Informant Mrs. Florence Huether

Address 1706 N. Bond Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-20-45 (month) (day) (year)

Cemetery or crematory Bay View Cemetery

Location Jersey City, N.J.

18. Funeral director Henry Sander & Sons, Inc.

Address North Ave. & Broadway

19. 1/18 (Date rec'd by registrar) 19 45 H. W. Hedrick per DeM. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 19 45 at 6 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 45, to Jan 17 19 45

and that I last saw h.. alive on Jan 16 19 45

Immediate cause of death	DURATION
Lobar Pneumonia	
arterial Hypertension	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. D. Lafferty M. D. or other

Address 1321 E. Baltimore St. Date signed 1/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

00223

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk P O 24
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Dundalk P. O. 24
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 Oak Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Washington Kramer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena Kramer nee Schaad 6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Oct. 6 - 1865

8. AGE: Years: 79 Months: 3 Days: 9 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Geo. Kramer; 13. Birthplace: Md.

MOTHER — 14. Maiden name: Ellen J Horn; 15. Birthplace: Md.

16. Informant: Mrs. Margaret Kramer
Address: 407 Oak Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 18-45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18. Funeral director: John G. Connelly
Address: 418 Eastern Ave. Essex

19. Jan. 16 1945 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1945, at 3P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from July 1 1944, to Jan 15 1945 and that I last saw h... alive on Jan 15 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerotic Cardio-Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo M. Baumgardner M. D. or other
Address: Baltimore Md Date signed: 1/15/45

Read
U.S.
1/18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (957)

CERTIFICATE OF DEATH

P 00224

Reg. Diat. No. 40

1. PLACE OF DEATH: Balto
County
City or town Carney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Carney
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2319 Wilker Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Louise Elsig Kuhne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife Albert Kuhne
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 3, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	13	hrs. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation house wife
11. Industry or business

FATHER
12. Name Henry Deckert
13. Birthplace Germany

MOTHER
14. Maiden name not known
15. Birthplace Germany

16. Informant Clarence Kuhne
Address 3214 Chesterfield Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22/45 (month) (day) (year)
Cemetery or crematory Parkwood
Location Taylor Ave.

18. Funeral director Clarence F. Hoffmann
Address 1639 N. Broadway

19. 1/22 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 19 45, at ? M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19
and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Rheumatic Heart	
Due to Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D., or other
Address Date signed January 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

00225 P

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2117 Gwynn Oak Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2117 Gwynn Oak Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GLENCOE WILLIAM LEIST

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna G. Leist
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 9, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	19	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Cemetery Sup't. - Retired
11. Industry or business

FATHER
12. Name: Frederick Leist
13. Birthplace: Germany

MOTHER
14. Maiden name: Isabelle Horn
15. Birthplace: Scotland

16. Informant: Mrs. Edna G. Leist
Address: 2117 Gwynn Oak Ave., Woodlawn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/31/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27, 1945 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 43, to Jan 27 1945
and that I last saw him alive on Jan 27 1945

Immediate cause of death	DURATION
Acute Congestive Heart Failure	2 days
Due to Hypocondelitis	2 years
Due to Arteriosclerosis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. C. Smith M. D. or other
Address 4509 Baltimore Ave. Date signed Jan 29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00226

CERTIFICATE OF DEATH

Reg. Dist. No. #30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 400 Newburg Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ferdinand Leppla LEPPLA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Louisa
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 6 1880

8. AGE: Years: 64 | Months: 5 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER
12. Name: Phillip Leppla
13. Birthplace: Germany

MOTHER
14. Maiden name: Karolyn Knecht
15. Birthplace: Germany

16. Informant: Mrs. Ferdinand Leppla
Address: 400 Newburg Ave.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18. Funeral director: George A. Farley
Address: Catonsville, Md.

19. 1/20/45 (Date rec'd by registrar) H. C. Andreas Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945, at 6.a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1945, to Jan. 20 1945 and that I last saw h— alive on Jan. 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 da.
Due to: Chronic Cardio-vascular-renal disease	8 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilson K. Gallagher M.D. M.D. or other
Address: 6209 Frederick Rd. Balto. 28 Date signed: 1-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-E)

CERTIFICATE OF DEATH

P 00227

Reg. Diat. No. 46

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 N. Monroe St., Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1 ✓

3.(a) FULL NAME: GEORGE W. LEWIS

3.(b) Social Security Number: 215-12-5728

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: /////

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11/23/87

8. AGE: Years	Months	Days	If less than one day
57	2	4	..... hrs. ..... min.

9. Birthplace: Conway, S.C.
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business:

FATHER — 12. Name: Thomas Lewis
13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Addie Shesion
15. Birthplace: South Carolina

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29, 1945 (month) (day) (year)
Cemetery or crematory: Bennettsville
Location: Bennettsville S.Carolina

18. Funeral director: Robert S. Little
Address: 2700 Edmondson Ave.

19. 1/29 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 45 at 915 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 19 45 to January 27 19 45 and that I last saw him alive on January 27 19 45

Immediate cause of death: Peritonitis, Generalized — DURATION: 3 days

Due to: Intestinal Obstruction — 4 days
Adhesions, intra-abdominal, Post-op. — unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Obstruction of bowels; generalized peritonitis — Date of op. 1-26-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. KENNEY, M.D. CLINICAL DIRECTOR
M. D. or other

Address: Fort Howard, Maryland Date signed: 1-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Rec d. U.S.
1/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

00228

Reg. Dist. No. 33

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 9 mo. 6 days.

Hospital, institution, or street address where death occurred:
Rosewood State Training School

How long in hospital or institution? 6 years, 9 months 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Ray Lewis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 29, 1921

8. AGE: Years	Months	Days	If less than one day
23	0	22	hrs. min.

9. Birthplace: Harford County
(Town, county, and state)

10. Usual occupation: Inmate; Rosewood State

11. Industry or business: Training School; Owings Mills

FATHER
12. Name: Romey Lewis
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Hallie McCoy
15. Birthplace: W.Va.

16. Informant: Institutional Records
Address: Rosewood State Training School

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27-45 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Fallston Harford Co

19. Funeral director: Martin Gehrig

Address: Jarrettsville, Md.

19. 1-26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 19 45 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 19 40 to Jan. 24 19 45

and that I last saw him alive on January 24 19 45

Immediate cause of death	DURATION
Aleukemic myeloid Leukemia	Unknown
Due to: Leukemia with Splenomegaly	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation

Date of op.: none

Autopsy results: Splenomegoly, Ascites

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C. Medairy M.D.
George C. Medairy, M.D., or other

Address: Owings Mills, Md. Date signed: 1/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-C)

CERTIFICATE OF DEATH

P 011229

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: 1808 Mayfield Avenue

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1808 Mayfield Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Emil Gottlieb Losch, Jr.

3.(b) Social Security Number: 218-07-2997

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 10, 1918

8. AGE: Years	Months	Days	If less than one day
26	4	2	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Supervisor

11. Industry or business: Glen L. Martins.

FATHER — 12. Name: Emil G. Losch, Sr.

FATHER — 13. Birthplace: Baltimore Md.

MOTHER — 14. Maiden name: Sophie Pfeiffer

MOTHER — 15. Birthplace: Baltimore Md.

16. Informant: Mr Emil G. Losch, Sr

Address: 1808 Mayfield Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17-45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: George L. Schwab

Address: 2101 Frederick Avenue Balto 9/4.

19. 1-16 45 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 19 45, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 44 to July 19

and that I last saw h.. alive on 1/13/45 January 13 45

Immediate cause of death: Osteo Sarcoma of Skull

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

DURATION
1 year

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas Reiss M. D. or other

Address: 2145 W Balto St Date signed 1/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

061250

Reg. Diat. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Ulutehall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ulutehall - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Winfield Males

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Bessie Males (nee Williams)
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Oct. 5, ~~1888~~ 1868

8. AGE: Years	Months	Days	If less than one day
76	3	24	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: J. V. Winfield Males
13. Birthplace: Unknown
MOTHER 14. Maiden name: Sarah Jane Males
15. Birthplace: Balto. Co. Md.
16. Informant: Mrs. Winfield Males
Address: Ulutehall, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 1, 1945 (month) (day) (year)
Cemetery or crematory: Stahlsville
Location: Parkton - Rural
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.
19. Jan 30, 1945 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1945 at 2:30 P.M.
CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1944 to Jan 26 1945
and that I last saw him alive on Sept 27, 45 1945

Immediate cause of death	DURATION
Cardiac Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Milton Bortner M. D.
M. D. or other
Address: White Hall Md. Date signed: Jan 29, 45

00231

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Glencoe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Glencoe
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emmerline Tracey Martin

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: James Thomas Martin
8.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): May 31, 1867

8. AGE:

Years	Months	Days	If less than one day
85	7	21	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Housemaid
11. Industry or business

FATHER
12. Name: Lego C. Tracey
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Martha J. Gerber
15. Birthplace: Balto. Co. Md

16. Informant: J. J. Martin
Address: Glencoe, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24 1945 (month) (day) (year)
Cemetery or crematory: Hereford Baptist Church
Location: Monkton R.F.D.
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. 1/24 1945 Anna Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1932 to Jan. 21 1945
and that I last saw her alive on Jan 19 1945

Immediate cause of death	DURATION
Uremia	
Due to: Chronic Nephritis	
Due to:	
Other conditions: Hypertension, Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. W. France M. D. or other
Address: Parkton, Md. Date signed: 1/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

D 011232

Reg. Diat. No. 40

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
Street No.: B'Ave. Todds Farm
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NORMAN MARTIN.

3.(b) Social Security Number: 213-07-8138

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Esther V. Martin
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
50			____ hrs. ____ min.

9. Birthplace: Lancaster, Pa. (Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: (Unknown) Martin
13. Birthplace: Pa

MOTHER
14. Maiden name: *
15. Birthplace: Pa

16. Informant: John Edward Kolb
Address: 26 Dundalk Ave. Dundalk Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/7/45 (month) (day) (year)
Cemetery or ~~crematory~~: Pequea
Location: White Horse, Pa.

18. Funeral director: William Cook Inc
Address: 1217 St Paul St

19. 1/5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 5 1945, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
COMPOUND FRACTURE SKULL	
FRACTURE, LEFT HUMERUS	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1-5-45
Where did injury occur? S.P.T. PT. (City or town) BALTO. (County) MD. (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: STRUCK BY STREET CAR Injured at work? NO

22. SIGNATURE: M B Davis M.D.
Address: Dundalk Md. Date signed 1/6/45

Re: Chgd. date of death from phone call from Dr. Brahms Office. 3-27-45 JH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(165)

Registered No. 41

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dundalk, Balto. Co.
(b) Street address 223 Parkwood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Parkwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY MEISNER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Wanda Meisner
15. Birthplace Unknown

16 (a) Informant Records (Police)
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 8 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH January 21, 1945, at 11:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to deep lacerations of mouth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-21-45 at 2:15 A. M.
(b) Where did injury occur? 223 Parkwood Rd, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Cut with instrument

23. Signature Robert L. Fretton M.D.
Medical Examiner.
Date signed March 6 1945

VS 151

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

00234 30

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Relay, 27, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Relay Sanitarium

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Towson, R.F.D-8 Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Harry Lee Merryman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 9, 1867

8. AGE: Years	Months	Days	If less than one day
77	11		..... hrs. ..... min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name George H. Merryman
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden name Mary Gorsuch
15. Birthplace Baltimore Co., Md.

16. Informant Sister: Laura V. Merryman
Address Towson, R.F.D.-8, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1944 (month) (day) (year)

Cemetery or crematory Cemetery- Merryman Family Burying Ground
Location

18. Funeral director Brooks Funeral Home
Address Sparks, Md.

1945 1-5 (Date rec'd by registrar) 1945 [signature] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1945 19..... at 9:55 A M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Dec. 21 1944, to Jan. 4 1945 and that I last saw him alive on Jan. 4 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Disease	1 mon
Due to Arterio Sclerosis	5 yrs.
Due to	
Other conditions Hypertension (Senile)	2 mos

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Towson Date signed 1/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00235

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No. Timber Grove Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Theresa L. Michael

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife J. Emory Michael
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1866

8. AGE: Years	Months	Days	If less than one day
78	4	4	..... hrs. ..... min.

9. Birthplace Balto. City (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John F. McConnell
13. Birthplace Ireland

MOTHER
14. Maiden name Jane Fisher
15. Birthplace Ireland

16. Informant J. Emory Michael
Address Glyndon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 45 (month) (day) (year)
Cemetery or crematory St. Charles Cemetery
Location Pikesville Md.

18. Funeral director J. F. Kline & Sons
Address Reisterstown, Md.

19. Jan 12 45 (Date rec'd by registrar) Grace Fox Albaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 19 45, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-14 19 40, to 1-11 19 45 and that I last saw h[illegible] alive on 1-10 19 45

	DURATION
Immediate cause of death: Cardio-Vascular Disease	7 da.
Due to: arteriosclerosis	4 yrs.
Due to:	
Other conditions: Bronchitis	10 da.

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Kaplan, M.D. M. D. or other
Address Reisterstown, Md. Date signed 1-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JAN 29 1945
BUREAU V & S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

31 00236 8

Reg. Dist. No. ....

1. PLACE OF DEATH:

County Balto.

City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ....

Hospital, institution, or street address where death occurred: 6729 Windsor Mill Rd.

How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)

Street No. 6729 Windsor Mill Rd. (If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME FRANK G. MICHEL, Jr.

3.(b) Social Security Number 220-09-3103

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Virginia H. Michel

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) June 12, 1911

8. AGE: Years	Months	Days	If less than one day
33	6	24	..... hrs. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual occupation Maintenance Dept.

11. Industry or business Bethlehem Fairfield Co.

FATHER 12. Name Frank G. Michel, Sr.

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Catherine Kirk

15. Birthplace Baltimore Co., Md.

16. Informant Mrs. Virginia H. Michel

Address 6729 Windsor Mill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/45 (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 1/8 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1945, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19.., to .... 19.. and that I last saw h.... alive on .... 19..

	DURATION
Immediate cause of death Acute Cardiac failure	
Due to	
Due to Chronic alcoholism	
Other conditions sudden death inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations ....

.... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work? ....

23. SIGNATURE Geo McKieffer Dep. Med. Exam of Balto. M. D. or other

Address 1010 Leeds av Date signed 1-6-45

Mr. Geo. L. M. Kiefer - 2470 Washington Blvd.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00237

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Glendale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Glendale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6926 Holabird Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daniel Boone Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Louisa Jane nee Baldwin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 20 – 1853

8. AGE: Years	Months	Days	If less than one day
91	5	8	..... hrs. ..... min.

9. Birthplace Miller, Ohio (Town, county, and state)
10. Usual occupation Retired (Engineer)
11. Industry or business
FATHER 12. Name James Miller
13. Birthplace Ohio
MOTHER 14. Maiden name Susan Z.
15. Birthplace Ohio
16. Informant Mrs. Nellie Snyder
Address 6926 Holabird Ave.
17. Burial, cremation, or removal. Which? Interm Date thereof Jan. 29-45 (month) (day) (year)
Cemetery or crematory Miller Cemetery
Location Chesapeake, Ohio
18. Funeral director John G. Connelly
Address 418 Eastern Ave. Balto
19. Jan. 29 1945 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January (month) 29th (day) 1945 at 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/5 1944 to 1/26 1945
and that I last saw h... alive on 1/24 1945
Immediate cause of death Uremia - Sclerotic heart disease — DURATION

Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Charles Flom M. D. or other
Address 325 Eastern Ave Date signed 1/28/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-2)

CERTIFICATE OF DEATH

D 00238 44

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Compass Rd

(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME Susan A. Monroe

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22. 1852

8. AGE: Years 92 | Months 8 | Days 2 | If less than one day ....hrs. ....min.

9. Birthplace W. Va

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name Benjamin Arnold

13. Birthplace W Va

MOTHER 14. Maiden name Susanna Dye

15. Birthplace W Va

16. Informant C. A. Monroe

Address Quarry Mills Md

17. Burial, cremation, or removal. Which?) Date thereof 1/26/45 (month) (day) (year)

Cemetery or crematory Shiloh Baptist

Location Parkersburg W Va

18. Funeral director Mitchell & Son Inc

Address 1219 E Fort Ave

19. 1/26 1945 Registered (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1945, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 1945 to Jan. 25 1945 and that I last saw h.. Pt alive on Jan. 24 1945

Immediate cause of death	DURATION
Heart Failure	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel Gertman, M.D.

M. D. or other

Address 901 Fuselage Ave Balto., 20. Date signed 1/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24

CERTIFICATE OF DEATH

0023

Reg. Diat. No. 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 13 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Ingleside Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Richard G. Morgenweck

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Mary V. Nordhause

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 12, 1867

8. AGE: Years	Months	Days	If less than one day
77	4	21	____ hrs. ____ min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: telephone linesman

11. Industry or business: C.&P. Telephone Company

FATHER
12. Name: Martin Morgenweck
13. Birthplace: Germany

MOTHER
14. Maiden name: Adelaide Schwab
15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

19. Funeral director: Wm. J. Tickner & Sons

Address: Baltimore, Md.

19. 1/3/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1945, at 8:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20, 1944, to Jan. 2, 1945 and that I last saw him alive on Jan. 2, 1945

Immediate cause of death	DURATION
Terminal pneumonia	2 days
Due to: Septicemia, undetermined etiology	3 days
Due to: Generalized arteriosclerosis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: R. E. Gardner, M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 1/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00240

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1022 Druid Hill Ave., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: Civilian

3. (a) FULL NAME

THOMAS MORRELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Puerto Rican	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): About 1879

8. AGE: Years	Months	Days	If less than one day
About 65?			..... hrs. ..... min.

9. Birthplace: Puerto Rico
(Town, county, and state)

10. Usual occupation: General Laborer

11. Industry or business: Unknown

FATHER
12. Name: "
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-11-45 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Arundel & Rd

18. Funeral director: A. Lee Oeler

Address: 4644 York Rd.

19. 1-12 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6, 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 1944, to Jan. 6, 1945 and that I last saw him alive on January 6, 1945

Immediate cause of death	DURATION
Heart disease, hypertension and coronary arteriosclerosis	Unknown
Due to:	
Due to:	
Other conditions: Nephrosclerosis	
Malnutrition; Psychosis: with cerebral arteriosclerosis; other somatic disease, incompetent	

(Indicate conditions, if any, giving rise to immediate cause of death)

Major findings of operations: None

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Kenney, M.D. CLINICAL DIRECTOR M. D. or other

Address: Fort Howard, Md. Date signed 1-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

00241

Reg. Diat. No. 3C

1. PLACE OF DEATH:

County Balto Co.

City or town 621 Harlem Lane

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Grace May Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) Nov 5 1944 6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
	2	7	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name George W. Morris.

13. Birthplace Maryland.

MOTHER

14. Maiden name Grace M Bercraft

15. Birthplace Maryland

16. Informant Grace Morris.

Address 621 Harlem Lane

17. Burial Date thereof 1/13/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Sheppard

Location Catonsville, Md.

18. Funeral director Edw. S. Blackwell

Address Catonsville, Md.

19. 1/13 19 45 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January, 12 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November, 5, 44 19 to Jan. 12, 45 19

and that I last saw her alive on January, 10 19 45

Immediate cause of death	DURATION
Gastro- enteritis; non-infectious a simple food upset from bad diet	3 days
Due to Prematurity. portable condition.	
Due to (Maternal Toxemia of Pregnancy))	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide O Date of .....

Where did injury occur? O (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury O Injured at work? O

23. SIGNATURE V. Lloyd Johnson M. D. or other

Address Catonsville Date signed 1-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

00242

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years, 9 months, 3 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? Catonsville 28, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George S. J. Mummert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Theresa Tormollon Mummert

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 9, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	14	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Pattern-maker

FATHER — 12. Name: Samuel O. Mummert

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Eliza Jane Jackson

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 27, 1945 (month) (day) (year)

Cemetery or crematory: St. Marys

Location: Hampden, Baltimore, Md.

18. Funeral director: Ebaston Sons

Address: 608 Frederick Ave.

19. 1/24 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 19 45, at 8:30 pm

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 18 22, to January 23 19 45

and that I last saw him alive on January 23 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage,	
Due to: intra ventricular	8 hours
Due to: Hypertensive cardiorenal vascular disease	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Spring Grove State Hosp. Date signed: 1-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00243

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:
Vets.Adm.Fac. Fort Howard, Maryland

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1901 E. 29th St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: WILLIAM F. NELSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie B. Nelson

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 11-13-1886

8. AGE: Years	Months	Days	If less than one day
58	1	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Postal Clerk

11. Industry or business:

FATHER
12. Name: Jacob Nelson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Ida Luckan
15. Birthplace: Germany

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 12, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Ullrich Funeral Home

Address: Baltimore, Maryland

19. 1/10 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1945 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1945, to January 9, 1945 and that I last saw him alive on January 9, 1945

Immediate cause of death	DURATION
Pneumonia lobular	6 Days
Due to	
Due to	
Other conditions: Acute ethyl alcohol poisoning	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE: C. J. KERNEY, M.D. CLINICAL DIRECTOR

Address: Fort Howard, Maryland Date signed: 1-9-45

EVIDENCE for changes in item 6b and addition of #3 shown on Film G92 1-24-45 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00244

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15
Hospital, institution, or street address where death occurred: 506 Edmondson ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 506 Edmondson ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John M. O'Dell

3. (b) Social Security Number: 216-05-8299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~Estella J. O'Doll~~ Estella J. O'Dell (Estella J. O'Doll, wife) 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.): May 22 1880

8. AGE: Years 64 | Months 7 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Gas Fitter

11. Industry or business: Plumbing Co

FATHER — 12. Name: John O'Dell

13. Birthplace: unknown

MOTHER — 14. Maiden name: Emma Taylor

15. Birthplace: Md

16. Informant: Mrs Estella J. O'Dell

Address: 506 Edmondson ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: John F Kenny Inc

Address: 715 Light St.

19. 1/8 19 45 (Date rec'd by registrar) ... Registrar

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 19 45 at 10-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to:	
Cardio vascular disease	
Due to:	
Other conditions: sudden death	
Inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Dep. Med Examr Geo. McKieffer Evans M.D. M. D. or other

Address: 1010 Leadenhall Date signed 1-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00245

CERTIFICATE OF DEATH

Reg. Dist. No. 195 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Jessups Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mattie Jane Oursler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: A. F. Oursler
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 16 - 1857

8. AGE: Years	Months	Days	If less than one day
87	9	28	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER — Name: John Henderson
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name:
15. MOTHER — Birthplace: Maryland
16. Informant: Mrs. W. LeRoy Carr
Address: Jessups Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 25-45 (month) (day) (year)
Cemetery or crematory: Wesley Methodist Cemetery
Location: Hampstead, Md
18. Funeral director: Lloyd Lauser
Address: Laurel Md.
19. 1/24/45 19..... Frank Shipley, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1945, at 2.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30th 1944, to Jan. 23rd 1945
and that I last saw h..er alive on Jan. 23rd 1945

	DURATION
Immediate cause of death: Myocardial Insuff.	7 wks
Due to: Hypertension	3 yrs.
Due to: arteriosclerosis	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D.
M. D. or other
Address: Savage, Md. Date signed 1/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00246

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 11 months, 17 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 11 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 Annabelle Avenue, Baltimore
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Owens

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Walter Owens

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 8, 1911

8. AGE: Years	Months	Days	If less than one day
33	10	23	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Thomas McCall
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bertha Pitts
15. Birthplace: Virginia

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-2-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn A.A.Co. Md.

18. Funeral director: H. Howard Strong

Address: 3707 W. North Ave.

19. 2/1/45 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 19 45, at 2:05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 41, to Jan. 31 19 45 and that I last saw h... or ...alive on January 30 19 45

	DURATION
Immediate cause of death:	
Chronic myocardial insufficiency	2 mths.
Due to:	
Hereditary spastic paraplegia	indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: --

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville 28, Md. Date signed 1-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd. U.S.
8/1/45

(39) 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

00247

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Mace Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alpha C. Peer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife Lyda Bell Peer nee Kelly 6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) May 13 - 1892

8. AGE: Years	Months	Days	If less than one day
52	8	6	....hrs. ....min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business Contractor
FATHER 12. Name Louis N. Peer
13. Birthplace Va.
MOTHER 14. Maiden name Clara J.
15. Birthplace Va.
16. Informant Mrs. Lyda Bell Peer
Address 515 Mace Ave. Essex
17. Trans. (Burial, cremation, or removal. Which?) Date thereof Jan. 20 - 45 (month) (day) (year)
Cemetery or crematory 2
Location Winchester, Va.
18. Funeral director John G. Connelly
Address 418 Eastern Ave. Essex
19. Jan. 20 1945 John G. Connelly (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1945, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 5 1944 to Jan 19 1945 and that I last saw h.... alive on Jan 19, 1945

Immediate cause of death	DURATION
Carcinoma of Lung	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Howard M. Hummel M. D. or other
Address Cockeysville Date signed 1/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00248

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Baltimore Co

City or town: North Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: North Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Pfeil

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: Conrad Pfeil

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Aug 20 1861

8. AGE:

Years	Months	Days	If less than one day
83	5	6	...hrs. ...min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation:

11. Industry or business: At Home

FATHER — 12. Name: John Gresens

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Dorothea Kuhn

MOTHER — 15. Birthplace:

18. Informant: Mrs Mary MacGill

Address: 3209 Dundalk Ave

17. Burial, cremation, or removal. Which?: Buried Date thereof: 1/29/45 (month) (day) (year)

Cemetery or crematory: Lehigh

Location: Balto

18. Funeral director: Welsh Funeral Home

Address: 2008 Orleans St

19. (Date rec'd by registrar): 1/26/45 Registrar: Thomas Moore

MEDICAL CERTIFICATION

45

20. DATE OF DEATH: Jan 25 19 45 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 44 to Jan 25 19 45

and that I last saw h.. alive on Jan 25 19 45

Immediate cause of death	DURATION
Arteri-Sclerotic Cardio Vascular Disease	6 days
Due to: Coronary Occlusion	5 min
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W B Davis M.D.

M. D. or other

Address: Dundalk Md Date signed: 1/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00249

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County BALTIMORE
City or town ARBUTUS
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County BALTIMORE
City or town ARBUTUS Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1316 BIRCH AVE
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Herman Pieper

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	WIDOWED ~~Married~~

6 (b) Name of husband or wife Dora E. Pieper
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 27 1873

8. AGE: Years 71 | Months 6 | Days 19 | If less than one day ——hrs. ——min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business —

FATHER 12. Name Gustav F. Pieper
13. Birthplace Germany

MOTHER 14. Maiden name Augusta Eichmann
15. Birthplace Germany

18. Informant Pieper
Address 1316 Birch Ave Arbutus Md

17. BURIAL (Burial, cremation, or removal. Which) Date thereof 1/18/45 (month) (day) (year)
Cemetery or crematory Westlawn
Location Baltimore, Md.

18. Funeral director F. B. WIPPERT-SON
Address Baltimore, Monroe, Sts

19. Jan 18 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1945, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6th 1945 to Jan. 15th 1945 and that I last saw him alive on Jan. 14th 1945

Immediate cause of death Uremic coma — DURATION 9 days
Due to Arteriosclerosis — 3 yrs.
Due to Chr. Nephritis — 5 yrs.
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE M. J. McDermott M. D.
M. D. or other
Address 1136 Poplar Grove St Date signed 1/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Mrs. Bennett
1136 Poplar Street

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of ~~death clearly~~ and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

00250

8

CERTIFICATE OF DEATH

Reg. Dist. No. 9 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 4 mo. 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 Homestead St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Irene Pilkerton

3. (b) Social Security Number 216-18-9432

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 2 1923

8. AGE: Years 22 Months Days 5 If less than one day ... hrs. ... min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual occupation Mechanic
11. Industry or business Glenn L. Martin
FATHER 12. Name Louis A. Pilkerton
13. Birthplace St. Mary's Co. Md
MOTHER 14. Maiden name Renna Bellmore
15. Birthplace Balto Md
16. Informant Personal History Hospital Records
Address Eudowood Sanatorium Towson 4, Md.
17. B— Date thereof 1 10-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Louden Park
Location —
18. Funeral director Mary M. Wudefeld
Address 5? E 25th St
19. 1/18/45 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1945, at 5.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8, 1944 19.. to Jan 6 1945
and that I last saw h.er alive on Jan 5 1945

Immediate cause of death Pulmonary TBC — DURATION 1 yr
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE W. A. Bridges M. D. or other
Address Towson, Maryland Date signed

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

00251

CERTIFICATE OF DEATH

Reg. Diat. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 5 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford Co.
City or town R.F.D.#2, Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war. ✓

3.(a) FULL NAME Mrs. Mary Plummer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Albert Plummer
6.(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) March 22, 1911

8. AGE: Years	Months	Days	If less than one day
33	10	0	...hrs. ...min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Barbre
13. Birthplace Virginia
MOTHER 14. Maiden name Emma Jones
15. Birthplace Virginia
16. Informant Mrs. Mary Plummer
Address R.F.D.#2, Aberdeen, Harford Co., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1945 (month) (day) (year)
Cemetery or crematory Mt. Zion Cemetery
Location Belair, Harford Co., Md.
18. Funeral director Dean & Foster
Address Belair, Maryland
19. Jan. 22, 19 45 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 45 at 3:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 19 45, to Jan. 22, 19 45
and that I last saw her alive on January 22, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 yrs., 10 mos.
Due to Tubercle Bacilli	
Due to	
Other conditions Tuberculous Empyema	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stewart S Shaffer M.D. M. D. or other
Address Mount Wilson, Md. Date signed 1/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

00252

CERTIFICATE OF DEATH

Reg. Dist. No. 9-38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo, 25 days

Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? 2 mo - 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co

City or town: Pasadena

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Charles Pulley Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 5 1924

8. AGE: Years	Months	Days	If less than one day
20	3	11	..... hrs. ..... min.

9. Birthplace: Robinson, Ind
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John C. Pulley

13. Birthplace: New Orleans, La.

MOTHER — 14. Maiden name: Ida Barnes

15. Birthplace: Baltimore, Md.

16. Informant: Personal History, Hospital Records

Address: Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18/45 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie Md.

18. Funeral director: B. L. Hopkins

Address: Annapolis, Maryland

19. Jan 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1945 at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Jan 16 1945

and that I last saw him alive on Jan 15 1945

Immediate cause of death	DURATION
Pulmonary TBC	2 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C C Bridges M. D. or other

Address: Towson, Maryland Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00253

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: New N. Pt. & Battle Grove Rd.

How long in hospital or institution? 45 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: New N. Pt. & Battle Grove Rd
(If rural, give LOCATION)

2.(a) If veteran, name war: (On Wm J. Bardonski farm)

3. (a) FULL NAME: Steve Rehak

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single?

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): —

8. AGE: Years	Months	Days	If less than one day
about 80			hrs. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: John Rehak
13. Birthplace: Austria

MOTHER
14. Maiden name: Helen Vanek
15. Birthplace: Austria

16. Informant: Frank Rehak

Address: 1030 Castle St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-18-45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto. Md.

18. Funeral director: Frank Enoch & Son.

Address: 900 N. Chester St.

19. 1/16/ 1945 (Date rec'd by registrar) J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
3rd degree burns	
Due to: Explosion Barn	
Due to: Burning Shack	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. M. Carmine M.D.
Deputy Medical Examiner
M. D. or Other

Address: Dundalk, Md. Date signed: 1/16/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-d) Reg. Dist. No. 32

CERTIFICATE OF DEATH

00254

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Rockdale (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 8007 Shelly Drive
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 58 years

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Sherwood Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Hannah Webb Rhodes

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Benjamin Franklin Rhodes

6. (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) July 5, 1854

8. **AGE:** Years 90 | Months 6 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Mr. Webb
13. Birthplace United States

MOTHER
14. Maiden Name Unknown
15. Birthplace United States

16 (a) Informant Mrs. Florence Buckman
(b) Address 104 Sherwood Ave., Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) 1-22-45 (Date rec'd by registrar) (b) Dr. E. E. Nichols M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death January 19 1945, at 7.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943, to Jan. 19th 1945, and that I last saw him alive on Jan. 19th 1945.

Immediate cause of death	Duration
Chronic Myocarditis	2 yrs
Due to Coronary Sclerosis	2 yrs
Due to Art. Sclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A. Miller M. D. or other
Address Reisterstown Rd & Walker Ave, Pikesville, Md.
Date signed 1/22/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

00255

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore

City or town (Rural) Owings Mills Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs, 1 mon, 15 days

Hospital, institution, or street address where death occurred:

Rosewood State Training School

How long in hospital or institution? 17 yrs, 1 mon, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Church Hill Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME John Henry Rochester

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/6/'81

8. AGE: Years	Months	Days	If less than one day
63	2	19	12 hrs. 0 min.

9. Birthplace Church Hill, Md (Town, county, and state)

10. Usual occupation Inmate, Rosewood State

11. Industry or business Training School

FATHER 12. Name John McCleary Rochester

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Ella Meredith

MOTHER 15. Birthplace Maryland

16. Informant Institutional Records

Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Jan. 29 1945 (month) (day) (year)

Cemetery or crematory Church Hill Cem.

Location Queen Anne Co.

18. Funeral director Edgar L. Lane

Address Church Hill Md.

19. Jan. 28 1945 (Date rec'd by registrar) Grace McAbee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Jan 1945, at 12 noon M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 15 Jan 1945 to 26 Jan 1945

and that I last saw him alive on 26 Jan 1945

Immediate cause of death	DURATION
Bronch-Pneumonia	24 days
Due to Acute Bronchitis	26 days
Due to	
Other conditions Chronic Atrophic Arthritis	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. G. Fiddler M. D. (M. D. or other)

Address Owings Mills Md. Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-6) Reg. Dist. No. 33 P

CERTIFICATE OF DEATH

00256

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Reisterstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Mt. Pleasant Sanatorium.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 mos.

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2332 Ocala Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? 25 years

3 (a) **FULL NAME** Samuel Rosenberg.

3 (b) If veteran, name war

3 (c) Social Security No. 213-03-6932

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rebecca Chase Rosenberg

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) November 18, 1873

8. AGE: Years 71 Months 2 Days 5 If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Tailor

11. Industry or business

FATHER 12. Name William Rosenberg

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Bessie Chase

MOTHER 15. Birthplace Russia

16 (a) Informant Rebecca Rosenberg

(b) Address 2332 Ocala Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Beth Shalom Cemetery

Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.

(b) Address 1124-26 W. North ave

19 (a) 1-24-45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death January 23 1945, at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22, 1943, to Jan 23, 1945, and that I last saw him alive on Jan 23, 1945

Immediate cause of death	Duration
Myocardial Collapse.	
Due to Cancer	9 mos.
Due to Pulmonary Tuberculosis	18 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert J. Shmei M.D (M. D. or other)

Address Reisterstown, Md. Date signed Jan. 23, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87c)

00257

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3013 Ritchie Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3013 Ritchie Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bertha E. Rottack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Harry W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1876

8. AGE: Years	Months	Days	If less than one day
69		2	..... hrs. ..... min.

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Louis Weissert
13. Birthplace: Germany

MOTHER
14. Maiden name: Bertha Weissert
15. Birthplace: Germany

16. Informant: Harry W. Rottack
Address: 3013 Ritchie Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-30-45 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Maryland

18. Funeral director: Harry H. Witzke
Address: 4101 Edmondson Ave.

19. Jan 29 1945 (Date rec'd by registrar) D. T. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 45, to Jan 26 19 45; and that I last saw h.. alive on Jan 25 19 45

	DURATION
Immediate cause of death: Subdural scar from hematoma	15 yrs.
Jacksonian convulsion	72 hrs.
Due to: Subdural hematoma	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. G. Davidson M.D.
M. D., or other
Address: 520 D St. Sp Pt 9 Md Date Signed 1-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Robert Windsor
520 D. St
SE DC 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00258

Reg. Diat. No.

1. PLACE OF DEATH:
County: Balto
City or town: Halabird
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred:
1955 Walnut Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infonts give residence of mother)
State: Md County: Balto
City or town: Halabird
(If outside city or town limits, write RURAL and give oearest town)
Street No. 1955 Walnut Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: n/

3. (a) FULL NAME Elizabeth Scheeler

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Frank Scheeler
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): Mar 3rd 1881

8. AGE: Years	Months	Days	If less than one day
63	10	15	hrs. min.

9. Birthplace: Lancaster Co. Pa
(Town, county, and state)
10. Usual occopation: Housewife
11. Industry or business: At Home
FATHER 12. Name: Fred Stroble
13. Birthplace: Germany
MOTHER 14. Maiden name: Catherine (Unknown)
15. Birthplace: Germany
16. Intormant: Violetta Kline
Address: 900 Eastern Ave - Balto. Md.
17. Removal (Kurial, ~~cremation, or~~ removal. Which?) Date thereot 1/22/45 (month) (day) (year)
Cemetery or ~~Crematory~~: Concordia Ev. Luth Church Cemetery
Location: Chestnut Hill Lancaster Co. Pa
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.
19. 1-19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18 19 45 at 2:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 19 44, to Jan. 18 19 45
and that I last saw h.~~e~~ alive on Jan. 18 19 45

Immediate cause of death	DURATION
Retro-Peritneal Sarcoma	6 Mo.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)
Major findings nf operatioos: Retro-Peritneal Sarcoma
Date of op. Nov. 11, 1944
Antopsy results
PHYSICIAN: Please nnderlioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (Coooty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Eugene P. Evans M.D.
M. D. or other
Address: 1 Liberty Parkway Date signed 1-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00259

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred: Masonic Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2658 W. North Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George Gustav Schnaufer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mollie Schnaufer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 31 - 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	4	12		

8. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Own Shop

FATHER
12. Name: John Schnaufer
13. Birthplace: Germany

MOTHER
14. Maiden name: Barbara Schaffer
15. Birthplace: Germany

16. Informant: Laura M. Schroeder

Address: Masonic Home, Catonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)

Cemetery or crematory: Union Bridge

Location: Md

18. Funeral director: Geo. L. Beyer Jr.

Address: 1512 Hollins St.

19. Jan 12 1945 (Date rec'd by registrar) L.M. Schroeder Registrar

Jan. 16-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 19 45 at 2 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 38 to Jan 12 19 45 and that I last saw h alive on Jan 12 19 45

Immediate cause of death	DURATION
Cardiac Decompensation	3 days
Due to: Hypertensive Cardio Vascular Disease	3 yrs
Due to: Prostate Hypertrophy	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. Wilbur F. Skillman M. D. or other

Address: 6 E. Biddle St. Date signed: 1/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

00260

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week + 1 day

Hospital, institution, or street address where death occurred: Haarlem Lodge

How long in hospital or institution? 1 week + 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Balto (If outside city or town limits, write RURAL and give nearest town)

Street No. 1820 Mureland Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah Schwab

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Jacob Schwab

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 69 Months: Days: If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Isaac Cohen

FATHER — 13. Birthplace: Russia

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace: Russia

16. Informant: Mr. JACOB SCHWAB

Address: 225 W. 23rd St. New York N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-45 (month) (day) (year)

Cemetery or crematory: Hebrew Nursery Inc

Locefion:

16. Funeral director: Jack Levin Inc

Address: 1589 E. Balto St

19. 1/4 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4 19 45 at 12 37 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 26 1944 to Jan. 4 1945 and that I last saw h.. alive on 1/3/45 19

Immediate cause of death	DURATION
Cardiovascular Renal Failure	1/3/45
Due to: Hypertensive & Arterio Sclerotic Cardiovascular	
Due to: disease	5 yrs
Other conditions: Toxic Psychosis	1 month

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: 3629 E. Lombard Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

00261

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years, 5 months, 23 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 14 years, 5 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4017 Norfolk Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rose Shapiro

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Morris Shapiro

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 15, 1863

8. AGE: Years	Months	Days	If less than one day
81	4	14	hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Isadore Seltzer

FATHER 13. Birthplace: Russia

MOTHER 14. Maiden name: Jessie ?

MOTHER 15. Birthplace: Russia

16. Informant: Hospital records

Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-30-45 (month) (day) (year)

Cemetery or crematory: Hebrew Rel

Location: Baltimore

18. Funeral director: Joseph Lewis Inc.

Address: 1439 E Balto St

19. 1/29/45 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 19 45, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 19 31, to January 29 19 45

and that I last saw her alive on January 29 19 45

Immediate cause of death	DURATION
Acute exacerbation of chr. myocardial insufficiency	12 days
Due to: Lobar pneumonia, left lower lobe	"
Due to: Hyertensive cardiovascular-renal disease.	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. Robert E. Gardner, M.D. M. D. or other

Address: Baltimore-28, Md. Date signed: 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

00262

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: St. Helena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: St. Helena

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles J. Skinner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21 - 1900

8. AGE: Years: 44 Months: Days: If less than one day: hrs. min.

8. Birthplace: N. Carolina (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Robert Skinner

13. Birthplace: N. Carolina

MOTHER 14. Maiden name: Silesta Weaver

15. Birthplace: N. C.

16. Informant: Sister

Address: N. C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/13/45 (month) (day) (year)

Cemetery or crematory: ?

Location: N. Carolina

18. Funeral director: John D Connelly

Address: 418 Eastern Ave. Apt 21

19. 1/12/45 (Date rec'd by registrar) J Connelly (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1945, at 6.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M D Davis M.D.

Asst Dist Med. Examiner - Balto. County or other

Address: Dundalk Md. Date signed: 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00263

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 7 mos., 21 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 yrs., 7 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 651 W. Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Skirius

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Anna ?

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 29, 1887?

8. AGE: Years	Months	Days	If less than one day
57	5	24	...hrs. ...min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Brewery

FATHER — 12. Name: Vincent Skirius

FATHER — 13. Birthplace: Lithuania

MOTHER — 14. Maiden name: Eva ?

MOTHER — 15. Birthplace: Lithuania

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/45 (month) (day) (year)

Cemetery or crematory: Forest Chicago Ill.

Location:

18. Funeral director: Edw. S. MacNabb.

Address: Frederick Road

19. 1/27 19 45 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 19 45 at 9:55 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 19 43, to January 22 19 45

and that I last saw him alive on January 22 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	72 hrs.
Due to: Generalized artersclerotic cardiovascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Address: Baltimore-28, Md. Date signed 1/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00264

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or towe limits, write RURAL and give nearest town)

Street No.: Montgomery Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME James Sovoia

3. (b) Social Security Number 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feb 15 1878

8. AGE: Years: 66 | Months: 10 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: City of Baltimore

FATHER — 12. Name: James Sovoia

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden name: Rosaline Rose

MOTHER — 15. Birthplace: Italy

16. Informant: Mrs Mary Sovoia

Address: Montgomery Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/5/45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore Md

18. Funeral director: Wilson & Son Inc

Address: 1210 E Coul St

19. 1/4 (Date rec'd by registrar) 1945 [signature] Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945, at 10 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION

Coronary occlusion

Due to:

Due to: Cardiovascular Renal

Other conditions: Sudden Death Enquiry

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. M. Lieffer Dept Health M. D. or other

Address: 1015 Linden Ave Date signed: 1-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-C

CERTIFICATE OF DEATH

P 00265

Reg. Dist. No. C-4

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Facility, Ft. Howard, Maryland

How long in hospital or institution? 39 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Hamburg Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME WILLIAM E. SPENCE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	M---Sep

6.(b) Name of husband or wife Isabelle Spence

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 8-3-91

8. AGE: Years	Months	Days	If less than one day
53	5	9	...hrs. ...min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Bar Tender

11. Industry or business

FATHER 12. Name John Spence

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Jenny Riggs

MOTHER 15. Birthplace Virginia

18. Informant Clinical Records, Vets. Adm. Facility

Address Fort Howard, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof 1 18 45 (month) (day) (year)

Cemetery or crematory National Cemtey

Location Balto.

18. Funeral director Walter B. Suggs

Address 189 W. Hamburg Street

19. 1-19-45 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1945, at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1944, to January 13, 1945

and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Transverse Myelitis at level	
second dorsal segment	6 Weeks
Due to Meningo-vascular syphilis	
Due to	
Other conditions Ulcers, multiple, decubitus	
Cellulitis, perineun and scrotum	

(Include pregnancy within 3 months of death)

Major findings of operations none ... Date of op. ...

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

28. SIGNATURE C. J. Kenney M.D.

C. J. KENNEY, M.D. CLINICAL DIRECTOR M. D. or other

Address Fort Howard, Maryland Date signed 1-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G 94 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (57)

CERTIFICATE OF DEATH

Reg. Dist. No. 00266

1. PLACE OF DEATH:

(a) County Balto Co Md

(b) City or town Middle rivver (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Middle River (If outside city or town limits, write RURAL and give town)

(d) Street No. Pond Rd # 20 (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Jerome Charles Stachowski

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 1943

8. AGE: Years	Months	Days	If less than one day
1	4+6		____ hr. ____ min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Carol Stachowski

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Elsie Kochanowski

MOTHER 15. Birthplace Balto Md

16 (a) Informant Carol Stachowski

(b) Address Pond Rd Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary

Location Balto Co

18 (a) Funeral director James J Bauernschub

(b) Address 1402 Fallsway Balto Md

19 (a) 1/3/45 (Date rec'd by registrar) (b) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. Date of death Jan 2 1945, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1944, to Jan 2 1945, and that I last saw him alive on Jan 1 1945.

Immediate cause of death	Duration
Uremia	12 hours
Pneumonia, Bronchial, c/w G.U.	
Due to Acute Bronchitis	
tracheo-bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo M. Baumgardner M. D. or other

Address Balto 6 Date signed 1/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00267

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Randallstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Court Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Steir

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Leonhard Steir

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 17, 1870

8. AGE: Years 74 | Months 5 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Franz Schuler

13. Birthplace Germany

MOTHER

14. Maiden name Sophie Mikiolek

15. Birthplace Germany

16. Informant Leonhard J. Steir

Address Evergreen Oak Sta. Balto 7

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Taylor Ave. Baltimore

18. Funeral director Frank Fennell

Address Pikesville Md

19. 1/13/ 1945 Wm. E. Martin

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1945, at 1 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Jan 13, 1945

and that I last saw h[illegible] alive on Jan 12, 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Md Date signed 1/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

00268

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Belair Road &Gunpowder Falls
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME John Stricklin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Grace Rebeccah Stricklin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25th. 1871

8. AGE: Years	Months	Days	If less than one day
73	0	3	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation Truck Farmer
11. Industry or business

FATHER
12. Name John Stricklin
13. Birthplace Carroll Co. Maryland

MOTHER
14. Maiden name Elizabeth
15. Birthplace Carroll Co. Maryland

16. Informant Mrs. John Stricklin
Address Fullerton, Maryland

17. Burial Date thereof Jan. 31st. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Perry Hall Methodist
Location Fullerton Maryland
18. Funeral director Loshan Funeral Home
Address 7401 Belair Road
19. 1/29/45 19 J. D. Vannatta
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28th. 1945 19 at 4.15P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 19 45, to Jan. 28, 19 45
and that I last saw h— alive on Jan 28 19 45.

	DURATION
Immediate cause of death Coronary Thrombosis	4 days
Due to Coronary Sclerosis	
Due to Heart Disease	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.
M. D. or other
Address Fork, Md. Date signed 1/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

00269

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Yrs.

Hospital, institution, or street address where death occurred:

17 Beaumont Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Beaumont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Nelson Stuart

3. (b) Social Security Number: 219-22-7278

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie C.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Febuary 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	2	hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Nichols Co.

FATHER — 12. Name: David Stuart

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Rachel Phelps

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs. Jennie C. Stuart

Address: 18 Beaumont Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/23/45 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Greenmount Ave.

18. Funeral director: William J. Tickner & Sons

Address: North & Pa[illegible] Aves.

19. 1/20 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 5 1941 to January 20 1945 and that I last saw h[illegible] alive on January 17 1945

Immediate cause of death	DURATION
Myocarditis, Degenerative & Senile	
Due to: Arteriosclerosis	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: 0 Injured at work?

23. SIGNATURE: A. Stone Johnson M. D. or other

Address: Catonsville Md. Date signed: 1-20-45

Dr. Lloyd Johnson

610 Frederick Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00270

Reg. Dist. No. 47

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2960 Yorkmay

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frances A Sullivan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14th 1936

8. AGE: Years	Months	Days	If less than one day
8	10	12	..... hrs. ..... min.

9. Birthplace: Baltimore Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business: School

FATHER
12. Name: Vernon Sullivan
13. Birthplace: Va

MOTHER
14. Maiden name: Lucille Farrell
15. Birthplace: Va

16. Informant: Vernon Sullivan

Address: 2960 Yorkmay

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/27/45 (month) (day) (year)

Cemetery or crematory: Charlottesville Va

Location

18. Funeral director: Wells Funeral Home

Address: 2008 Orleans

19. 1/29/45 (Date rec'd by registrar) 19.. W M Leasmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26. 19.45, at 6 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..44.. to Jan 26 19..45

and that I last saw h.. alive on Jan 25 19..45

Immediate cause of death	DURATION
Pneumonia Lobular	4 hrs
Due to: Congenital Debility Mental Defic	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J W Edwards M.D.

M. D. or other

Address: Dundalk Md Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00271

Reg. Diat. No. 42

1. PLACE OF DEATH:
County Baltimore County
City or town English Consul
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town English Consul
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3424 First Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Johanna Unger

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Herman A Unger
7. Birth date of deceased (mo., day, yr.) April 23-1859 6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
85	9	7	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Wilhelm Siedow
13. Birthplace Germany

MOTHER
14. Maiden name unknown
15. Birthplace Germany

16. Informant Conrad H Unger
Address 2815 Rose Ave English Consul

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3-1945 (month) (day) (year)
Cemetery or crematory London Park Cemetery
Location Baltimore Md
18. Funeral director Frank H Seitz
Address 814 N 36 St Balto City

19. Feb 2 19 45 A. Gw. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 19 45, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 42, to Jan 30 19 45
and that I last saw h[er] alive on Jan 30 19 45

Immediate cause of death	DURATION
Cardiac failure	2 days
Due to Arteriosclerosis	
Due to	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul Schonfeld M. D. or other
Address 1305 E Monument Date signed 1/31/45

M

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00272

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 615 N. Collington Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Volkman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Volkman
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 10/4/1870

8. AGE: Years	Months	Days	If less than one day
74	? 3	11	hrs. min.

9. Birthplace: Balto. Md
(Town, county, and state)
10. Usual occupation: ? Housewife
11. Industry or business: ? At Home
FATHER 12. Name: ? John Volkman
13. Birthplace: ? Germany
MOTHER 14. Maiden name: ? Susanna Swartzkopf
15. Birthplace: ? Germany
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/17/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road
18. Funeral director: Lilly + Zeiler Sr
Address: 403 S. Wolfe St.
19. 1/16 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1945, at 5:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1945, to January 15 1945
and that I last saw her alive on January 15 1945

Cause	Duration
Immediate cause of death: Terminal hypostatic bronchopneumonia	24 hrs
Due to: Generalized arteriosclerosis c hypertensive card. vasc disease	Indef
Due to: Myocardial insuff.	48 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. — M. D. or other
Address: Baltimore-28, Md. — Date signed 1/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

(01273)

Reg. Dist. No. 44

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

City or town: Essex Eastern Terrace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County

City or town: Essex Eastern Terrace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 26 Riverside Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah E. Wade

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Andrew J Wade

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1856

8. AGE: Years	Months	Days	If less than one day
89	7	4	..... hrs. ..... min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Phillip Daughtery
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Ann Warfield
15. Birthplace: Md.

16. Informant: Mrs. Margaret E. Heath

Address: 26 Riverside Rd, Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Annapolis Blvd AA Co.

18. Funeral director: John F Kenney Inc.

Address: 715 Light St.

19. Jan. 29 1945 (Date rec'd by registrar) J. D. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27th 1945 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1945 to Jan 27 1945

and that I last saw h.e.r. alive on Jan 27 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward McKenney M. D. or other

Address: Essex Md Date signed 1/29/45

Dr Hummel

417½ Eastern

STATE OF MARYLAND—CERTIFICATE OF DEATH

D0274

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County BALTO Registration Dist. No. 30

Village or City CATONSVILLE No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 20 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME CHARLES WALDSCHMIDT

(a) Residence: No. 38 OVERBROOK Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ CAROLINA J.

6. DATE OF BIRTH (month, day, and year) JAN 30 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. RETIRED

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) BALTO MD.

FATHER

13. NAME GEO. WALDSCHMIDT

14. BIRTHPLACE (city or town) (State or country) GERMANY

MOTHER

15. MAIDEN NAME ELIZABETH NAGENGAST

16. BIRTHPLACE (city or town) (State or country) ~~GERMANY~~ BALTIMORE, MD.

17. INFORMANT CAROLINA J. WALDSCHMIDT

(Address) 38 OVERBROOK Rd

18. BURIAL, ~~CREMATION~~, OR REMOVAL

Place LONDON PK. Date 1/23/45, 19

19. UNDERTAKER Geo Lesmbach & Sons

(Address) 525 N. Lyndhurst St

20. FILED 1/~~2~~3/45 Edna V. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH JAN 20 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from OCT. 1, 1944, to JAN. 20, 1945

I last saw him alive on JAN. 18, 1945; death is said to have occurred on the date stated above, at 5:45 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
RECTAL DIVERTICULUM (PROBABLY CANCEROUS)	UNKNOWN

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Harvey Howell Schmidt M. D.

(Address) 933 HANOVER ST., BALTO., MD.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Sept 27
5 A.M. 28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-B)

00275

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2879 Tennessee Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louise Wegworth

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles Wegworth
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec 22. 1870
8. AGE: Years 74 | Months 1 | Days 9. | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name ?
FATHER 13. Birthplace ?
MOTHER 14. Maiden name ?
MOTHER 15. Birthplace ?
16. Informant: Mrs. Daniel L. Ammer
Address 603 Allendale St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1945 (month) (day) (year)
Cemetery or crematory: London Park
Location: City
18. Funeral director: M. Mrs. John W. Teufel & Son
Address 801 W Fayette St.
19. 2/2/45 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1941, to Jan 31 1945 and that I last saw h.er alive on Jan 29 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 hrs.
Due to: Chronic Nephritis	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R O Glenn M. D. or other
Address 2758 Hollins Ferry Rd. Date signed 2/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00276

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
145 Winters Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 145 Winters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ODEN WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1857

8. AGE: Years 87 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Prince George Co., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Samuel Williams
13. Birthplace: Md.

MOTHER
14. Maiden name: Rachel ?
15. Birthplace: Md.

16. Informant: Mrs. Ida Torsell
Address: 79 Winters Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-45 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Park
Location: Baltimore Co., Md.

18. Funeral director: Mrs. Frances A. Hemsley
Address: 578 W. Biddle St.

19. 2/3 (Date rec'd by registrar) 19 45 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31st 19 45 at 5.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30-44 19 to 1-31-45 19 and that I last saw him alive on 1-31-45 19

Immediate cause of death	DURATION
Mitral Insufficiency	?
Due to: Arterio-sclerotic Heart Disease	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. F. Maloney M.D. M. D. or other
Address: Catonsville Md. Date signed 2/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00277

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred: Spring Grove State Hospt.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 618 Inglewood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Van Evry M. Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Williams
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct 11, 1887

8. AGE: Years	Months	Days	If less than one day
57	2	25	hrs. min.

9. Birthplace: New York (Brooklyn)
(Town, county, and state)
10. Usual occupation: Moving Picture Operator
11. Industry or business: Hippodrome Theatre

FATHER
12. Name: Horace P. Williams
13. Birthplace: Culpepper, Va.

MOTHER
14. Maiden name: Louisa Allen
15. Birthplace: Balto., md.

16. Informant: Mrs. Mary G. Williams
Address: 618 Inglewood Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/8 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 19 45 at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 19 44 to Jan 6 19 45
and that I last saw him alive on Jan 6 19 45

Immediate cause of death	DURATION
Hypertensive Cardio Vascular renal	Before see Pt. Hx
Due to: Acute exacerbation myocard insufficiency	6 hours
Other conditions: Terminal bronchopneumonia bilateral	48 hours

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John G. Kunkel M.D.
M. D. or other
Address: Catonsville Md Date signed 1-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00278

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2141 Homewood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ANNIE WILLIAR

3. (b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Edward R. Williar

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	11	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: William S. McCullough
13. Birthplace: S. C.

MOTHER
14. Maiden name: Catherine Berry
15. Birthplace: Unknown

16. Informant: Miss Mildred McCullough

Address: 1409 N. Collington Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/45 (month) (day) (year)

Cemetery or crematory: Balto. Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 1/24 19 45 Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23, 19 45 at 7:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 19 44 to Jan 23 19 45 and that I last saw her alive on Jan 22 19 45

Immediate cause of death	DURATION
Pericerae Hemorrhage	2 days
Due to: Pericerae Cerebral Edema	5 hrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed 1-24

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

00279

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo 15 da
Hospital, Institution, or street address where death occurred: Spring Grove Hospital
How long in hospital or institution? 9 mo 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 743 Chester
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wm. Edward Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Blanch Blizzard Wilson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-21-1860

8. AGE: Years	Months	Days	If less than one day
84	7	15	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Varnisher
11. Industry or business: Furniture

FATHER
12. Name: Wm. Wilson
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Hurd
15. Birthplace: Md.

16. Informant: Lottie Hess
Address: 743 N. Chester

17. Burial (Burial, ~~cremation, or removal~~) Date thereof 1/10/45 (month) (day) (year)
Cemetery or ~~crematory~~: Oak Lawn
Location: Eastern Ave - Extended
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 1/8 1945 W. C. Ardrey Jr. Deputy Local Reg.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945, at 8:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1944, to Jan 6 1945
and that I last saw him alive on Jan 6 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 da
Due to: Hypertension	Before
Cardio vascular	3-21-44
Due to: disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John G. Kunkel M.D.
M. D. or other
Address: Catonsville Date signed 1-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00280

Reg. Dist. No. 38 D

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2225 Ashton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Milton R Wood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1880

8. AGE: Years	Months	Days	If less than one day
64	4	23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Foreman Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: White Marsh Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Personal History Hospital Records
Address: Eudowood Sanatorium Towson 4, Md.

17. Burial in New Cathedral (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)
Cemetery or crematory
Location: Frederick Rd

18. Funeral director: Edward Faulkner
Address: 2359 Garrison Blvd.

19. 1/13/45 (Date rec'd by registrar) R. W. Hedrick per D.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12, 19 45, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1, 19 44, to Jan 12, 19 45
and that I last saw him alive on Jan 12, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7-1-1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. G. Bridges M. D. or other
Address: Towson 4 Maryland Date signed:

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 34

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~/Maryland
(b) Street address Berlin Ave Patapsco
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Patapsco Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Berlin Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Woods

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Myrtle Woods
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1890

8. AGE: Years 54 | Months 10 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county and state)

10. Usual Occupation Minister

11. Industry or business —

FATHER
12. Name Richard Woods
13. Birthplace Prince George Co Md.

MOTHER
14. Maiden Name Fannie Owens
15. Birthplace Prince George Co. Md

16 (a) Informant Myrtle Woods
(b) Address Berlin Ave Feb. 1- '45

17 (a) Mt. Calvary (b) Date thereof Feb. 1, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 2/1 '45 (b) C. W. Wedwick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 27 1945, to January 28 1945, and that I last saw h[illegible] alive on January 27, 1945.

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis + Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Howell M. D.
Address 601 N Carrollton Ave Date signed 1/31/45

VS 150

FEB 1 - 1945

Rec'd. U.S. 2/1/45

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

00282

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 14 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 524 W. Mulberry Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ella Worthington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William R. Worthington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3, 1860

8. AGE: Years	Months	Days	If less than one day
84	8	17	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records
Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-31-45 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland

19. 1/31 (Date rec'd by registrar) 1945 [signature] Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945 at 6:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1944, to January 20 1945 and that I last saw h.er alive on January 20 1945

	DURATION
Immediate cause of death: Terminal pneumonia	6 hrs.
Due to: Hypertensive cardiovascular disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed 1/20/45

PLEASE PRINT PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00283

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Point R.D. 2 Pa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Sparrows Point R.F.D. #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Kirkwood Anderson Wright

3.(b) Social Security Number: 183-05-8332

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

B.(b) Name of husband or wife: James A. Wright

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Nov. 6 - 1896

8. AGE:

Years	Months	Days	If less than one day
48	2	15	hrs. min.

9. Birthplace: Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business

FATHER

12. Name: Richard A. Anderson

13. Birthplace: Baltimore Co. Md.

MOTHER

14. Maiden name: Katherine Miller

15. Birthplace: Baltimore Co. Md.

16. Informant: James A. Wright

Address: Sparrows Point Pa R.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2-1945 (month) (day) (year)

Cemetery or crematory: West Liberty

Location: White Hall. R.F.D.

18. Funeral director: Howard S. Markline

Address: White Hall. Md.

19. Jan 31, 1945 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to Jan 31 1945 and that I last saw her alive on Jan 30 1945

	DURATION
Immediate cause of death: Coronary Occlusion	1 day
Due to: Arteriosclerosis	
Due to: Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Grace A. Free M.D. M. D. or other

Address: Sparrows Point Date signed: Jan 31 45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

000284

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Melvin Ave. & Old Fred. Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Jerome Frederick Wurstger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1894

8. AGE: Years	Months	Days	If less than one day
49	11	8	hrs. min.

9. Birthplace: Pimlico, Baltimore Co. Md. (Town, county, and state)
10. Usual occupation: Semi cripple
11. Industry or business

FATHER
12. Name: Charles Oliver Wurstger
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden name: Mary M. Carter
15. Birthplace: Perry Hall, Md.

16. Informant: Mrs. Mary M. Wurstger
Address: Melvin Ave. & Old Frd. Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 25, 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.

18. Funeral director: Easton Sons
Address: 608 Frederick Ave Catons. Md.

19. 1-24-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22, 1945, at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1943, to 1-22-45
and that I last saw h.... alive on 1-22-45

Immediate cause of death	DURATION
Pneumonia (Coronary)	1 day
Due to: Arterio-Vascular Dis	2 yrs.
Due to: Semi-Paralytic	49 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: 802 Bird Ave Catonsville 28 Md. Date signed: 1-22-45

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-a

00285

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Balto.
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3018 Edgewood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Maria Anna Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife John William Young
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1902

8. AGE: Years	Months	Days	If less than one day
42	7	27	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation at Home
11. Industry or business

FATHER
12. Name Ambrose Bannion
13. Birthplace Somerset Co. Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant John W. Young
Address 3018 Edgewood Ave. Parkville

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 30th 1945
(month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Road

19. 1/29 1945 Mc G. A. Finty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 27 1945, at 7.30 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~
..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coarctio-Renal-Vascular	
Due to Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. P. O. Myer Dep'y M Ex
M. D. or other
Address Towson Md Date signed Jany 27 1945

is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9320

CERTIFICATE OF DEATH

Reg. Dist. No. 32 P

0286

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Brighton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Brighton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6506 Fairmount Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles O. Zile

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth E. Zile

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 13, 1870

8. AGE:	Years	Months	Days	If less than one day
	74	1	24	..... hrs. ..... min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: Retired Linesman

11. Industry or business: Balto. Transit Co.

FATHER
12. Name: John Zile
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Huff
15. Birthplace: Md.

18. Informant: Mrs. Elizabeth E. Zile
Address: 6506 Fairmount Ave.

17. Burial (Burial, cremation, or removol. Which?) Date thereof: Jan. 9, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn, Md.

18. Funeral director: D. Howard Strong

Address: 3207 W. North Ave.,

19. 1/9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6, 1945, at 4.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1944, to Jan 6th 1945

and that I last saw him alive on Jan 6th 1945

Immediate cause of death	DURATION
Chronic Bronchitis	unknown
Due to Chronic Myocarditis	unknown
Due to Arterio Sclerosis	unknown
Other conditions Incurable Hernia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. B. Culor M. D.
M. D. or other

Address: 7201 York Rd Date signed 1-8-1945